TEENAGE PREGNANCY PREVENTION

IN CALIFORNIA

1995 POLICY ROUNDTABLE SERIES

REPORT

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California State Library Foundation
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EXECUTIVE SUMMARY

In June and July 1995 the California Family Impact Seminar (CAFIS) sponsored the four-part Teenage Pregnancy Prevention Policy Roundtable Series for state policymakers and their staff. The purpose of the Policy Roundtable Series was to: (1) provide these individuals with the opportunity to explore the myriad of issues surrounding teenage pregnancy with policy, program and research experts; and (2) identify policy and program options for further consideration. This report is a summary of that work. A total of twenty-three experts in program, policy, and evaluation research presented at the four Policy Roundtables, including 10 state program representatives. Transcripts of their presentations appear in a separate publication.

TEENAGE PREGNANCY IN CALIFORNIA: TRENDS AND CHARACTERISTICS

Teenage pregnancy rates and trends in California essentially mirror those of the nation as a whole. In California, as around the nation, most teens who become parents are from lower socio-economic backgrounds, are more likely to be a member of an ethnic minority group, and are more likely to live in neighborhoods in which teen pregnancy and violence are prevalent.

Age

Birthrates by teens are low at the earliest ages (12 and 13), but increase steeply as teenagers get older. This is mainly due to the corresponding increase in sexual activity over the course of adolescence, but also partially due to the fact that older teens are more likely to desire pregnancy.

Socio-Economic Status

Teenage mothers share a number of characteristics, many of which are also associated with poverty. They are commonly:

(1) the offspring of a teen mother and/or grow up in a single female headed household;
(2) live in neighborhoods in which teen pregnancy is common;
(3) attend racially isolated schools;
(4) have academic problems;
(5) have low educational and occupational goals;
(6) have dropped out of school;
(7) have more than five siblings; and
(8) have parents(s) who exercise lax control over dating.

Socio-economic status of the teenager contributes to her sexual activity, contraceptive use, and pregnancy outcomes. Teenage girls who come from the lowest socio-economic group are

most likely to initiate sexual activity at a younger age, to ineffectively use contraception, and to become teen parents. Conversely, girls from a higher socio-economic group are more likely to put off sexual activity until an older age, make effective use of birth control, and not become teen parents.

Race/Ethnicity

Hispanic teenagers in California have a higher rate of teen pregnancy than they do in other states. Pregnancies to African American teenagers in California are slightly lower than the national average.

- Between 1980 and 1992, Black and Hispanic teenage pregnancy rates rose dramatically, while pregnancy rates for White teenagers rose only marginally.

- Marriage rates for teen parents are highest among Hispanics. White and African American teen parents are equally unlikely to marry. Regardless, ninety percent of marriages to teenage parents end in divorce.

- Although race contributes to these same factors, race alone does not explain differences in sexual activity, contraceptive use, and pregnancy outcomes. Because race is so strongly correlated with socio-economic status, it becomes confused as a cause of adolescent pregnancy. In fact, when low-income Black families are compared to low-income White families (instead of a simple comparison of White families in general to Black families in general) most of the pregnancy trends commonly associated with race tend to disappear (Chilman, 1983).

Fathers of Children Born to Teens

Fathers of children born to teen mothers share similar characteristics of the teen mothers themselves: poverty, lack of education, and lack of educational and occupational aspirations. In addition, however, seventy percent of these fathers are in their twenties, averaging five years older than the mothers of their children. Furthermore, the younger the teen mother, the greater likelihood that the father of her child is more than five years her senior.

Sexual Abuse

This age difference brings up the question of sexual abuse.

- Some estimates hold that 65 percent of all teenage mothers have been victims of sexual abuse (Boyer & Fine, 1992).

- Research indicates that teenagers who were sexually abused as children have earlier and higher rates of sexual activity.

- This definition of sexual abuse does not include the sexual activity that takes place between the teen mother and her much older partner. Still, it begs the question, can sexual activity between a teenage girl and an adult male ever be consentual, or is it in fact, another form of sexual abuse?

UNDERLYING DEVELOPMENTAL, ENVIRONMENTAL, AND PSYCHO-SOCIAL ISSUES THAT LEAD TO TEENAGE PREGNANCY

Developmental Issues

Physical Issues

On average, adolescents currently reach puberty at age 12 and 1/2, the youngest it has been since the turn of the century. This decrease in the age of puberty has implications for adolescent sexual activity and childbearing. Puberty is the hallmark of physical readiness to initiate sexual activity and to bear children. Unfortunately, physical readiness does not correlate with emotional readiness, and most twelve year olds are neither emotionally or cognitively mature enough to become sexually active or teenage parents.

Psycho-Social Changes

Adolescence is a time of identity formation and consolidation. In order to forge a sense of personal identity, the adolescent must:

(1) Separate/individuate from his or her parents;
(2) Define oneself in relation to the larger culture;
(3) Experience a sense of competency and achievement;
(4) Form a sense of sexual identity and learn to relate to others in a mature, intimate way; and
(5) Develop a positive sense of self-esteem.

Each of these tasks is vital to the development of identity formation. Adolescents who do not master these tasks will experience self doubt as to personal and sexual identity issues. Early initiation of sexual activity can act as a means to form a sense of sexual identity or to define oneself in relation to the peer culture. Teenage pregnancy and parenthood can provide role identity for adolescents who suffer role confusion, or an experience of competency for adolescents who have no other means to do so.

Cognitive Changes

Adolescence marks the shift from childhood concrete operational thought, to formal operational thought, in which hypothetical, anticipatory events can be understood. In order to be able to anticipate sexual activity and evaluate its consequences, adolescents must achieve

formal operational capabilities that allow them to acknowledge the possibility of sexual intercourse, anticipate its consequences, and plan to use contraception.

Acquisition of these abilities, however, is influenced by adolescents' environment, culture, education, and personal experiences. If the childhood phase of concrete operational thought endures into adolescence, teenagers can develop a personal fable of the self as unique and invulnerable. This personal fable is believed to account for so many teenagers' beliefs that they will not get pregnant, despite sexual activity in the absence of birth control.

Psycho-Social Issues

Psycho-social issues examine teen pregnancy from a psychological perspective by attempting to explain adolescent girls' conscious and unconscious motivations to become pregnant. This approach assumes that pregnant teens suffer personality or family deficits that explain the decision to engage in early pre-marital sex, refrain form using birth control, and become pregnant.

- It has been suggested that adolescents who become pregnant have poor coping skills by which to manage the transition to adulthood.

- Emotional instability and unfulfilled emotional needs have been suggested as explanations for adolescent pregnancy.

- External locus of control, or a sense of inability to control one's environment, has also been posited as a cause of adolescent pregnancy. Girls who have this sense of powerlessness may become pregnant to experience a sense of mastery, or, conversely, out of a sense of defeat.

- It has also been suggested that low self-esteem propels teenage girls to seek love and affirmation via sexual activity and childbirth.

Environmental Issues

Poverty and its features have been found to be the most salient correlate of adolescent pregnancy (Hayes and Hofferth, 1987). Specifically, three general at-risk categories are most noteworthy.

Education

Girls who have academic problems or who drop out of school are more likely to become pregnant.

Aspirations

Teenage girls are more likely to become pregnant if they lack educational and occupational goals.

Neighborhood

Adolescents who grow up in climates of poverty, where family members, friends, and acquaintances commonly bear children in adolescence, will be shaped by that reality. Socio-economic and racial isolation exacerbate this set of circumstances, as teenage girls have little exposure to an alternative economic and social reality: one where parenthood is forestalled in the expectation of a brighter educational and occupational future.

TEENAGE PREGNANCY AND THE MEDIA

Accessibility, Content, and Impact of TV, Movies, and Music Videos

Research indicates that teenagers have easy access to television, movies, and music videos, and that the content of such mediums frequently depicts sexuality in an unrealistic light (Harris, 1988).

- By the time he or she graduates from high school, the average American teenager will have viewed 15,000 hours of television.
- American teenagers view nearly 14,000 instances of sexual material on TV each year.
- Studies show that television, movies, and music videos have a negative impact on adolescents' perceptions about sex, attitudes towards sexuality, and sexual behavior.

Media Campaigns to Change Sexual Behavior

As of yet, no evaluations of media campaigns to alter adolescent sexual behavior or curb adolescent pregnancy have been released. Given the strength and impact television, movies, and music videos have on adolescents, what can media campaigns hope to achieve?

(1) Provide knowledge and resources about contraceptive methods.
(2) Provide referral sources for family planning.
(3) Encourage adolescents to use contraceptive methods.
(4) Change social norms around adolescent sexual activity and contraceptive use.

What types of messages might provide an effective counterbalance to the pervasive sexual messages portrayed in pop culture? Evaluations of media efforts to curb adolescent smoking suggest that media campaigns follow these guidelines:

(1) Ensure that media interventions are coordinated with school curricula.
(2) Air a variety of advertisements frequently.
(3) Use teenagers to develop and test media messages.
(4) Use diagnostic and formative research to ensure that message styles work and apply to all targeted age groups.

SCHOOL- AND COMMUNITY-BASED TEENAGE PREGNANCY PREVENTION STRATEGIES

There are three major approaches to prevention of adolescent pregnancy:

(1) Persuade adolescents who have not had sex to delay sexual activity.
(2) Increase contraceptive use among those who have had sex.
(3) Provide meaningful alternatives to adolescent parenthood.

Each of these approaches can be initiated via schools, community-based organizations, or a combination of both.

Delaying Sexual Activity

Abstinence education programs seek to delay the onset of sexual activity among adolescent or pre-adolescent youth. Abstinence curricula usually focus on the importance of sexual abstinence until marriage, and provide basic information on reproduction, values, and ethics, or decision making and assertiveness skills training, or both. Abstinence programs typically do not discuss contraception.

Evaluations of abstinence based curricula have shown little success in preventing adolescent pregnancy or delaying sexual intercourse, although evaluations of abstinence curricula have been limited by generalizability and validity (Christopher & Roosa, 1990; Roosa & Christopher, 1990; Jorgenson, Potts, & Camp, 1993). Evaluation results of Postponing Sexual Involvement (PSI), a highly rigorous study of an abstinence based curriculum, are pending and eagerly awaited.

Increasing Contraceptive Use Via Sex Education

Sex education is one method by which to improve contraceptive use. Sex education programs seek to forestall the onset of sexual activity among virgin teenagers, while encouraging sexually active teens to contract. Kirby et al. (1984) analyzed eight school-based programs to increase contraceptive use and found that successful programs share the following features.

(1) Focus on few specific behavioral goals.
(2) Use social learning programs as a basis.
(3) Provide information about the risks of unprotected intercourse and ways to avoid it by using experiential activities to personalize the information.

(4) Include activities that address media and social impacts on sexuality.
(5) Discuss and strengthen individual values and group norms that counter unprotected sex.
(6) Provide exercises in which students can model and practice communication and negotiation skills.

Increasing Contraceptive Use Via Provision of Services

Provision of family planning services is another method by which to prevent adolescent pregnancy. Provision of family planning services typically takes place at clinics located within schools or linked to schools. Some clinics provide comprehensive health services, while others only provide reproductive health services. While results of programs have been inconsistent in their success in increasing contraceptive use or preventing pregnancies, evaluation has clearly indicated that provision of reproductive health services does not hasten the onset of sexual activity, nor does it increase its frequency.

Providing Meaningful Alternatives to Adolescent Parenthood

Life options programs seek to provide meaningful alternatives for poor teenagers who have fewer opportunities for a productive life. Rather than targeting adolescent sexual activity or pregnancy alone, life options programs focus on occupational opportunities and/or life management skills that encourage adolescents to set and achieve goals for their lives.

Evaluations of some life options programs such as the Teen Outreach Program have indicated that program participants do experience lower rates of school failure, school suspension, school dropout, and teen pregnancy than their non-program counterparts.

PREVENTING REPEAT TEENAGE PREGNANCIES

Pregnancies to teenagers who have already given birth occurs with alarming frequency. One out of every four births to teens in California is a repeat teen birth. Furthermore, repeat births to teenagers have significant consequences for the children of teen mothers and the teen mothers themselves.

Scope of the Problem and Characteristics of the Teen Mothers

Although teen parents seem to understand the negative consequences of having additional children before they are able to provide economic support, estimates hold many teen mothers become pregnant again within several years.

- In one study, 43 percent of teen mothers had a repeat pregnancy within three years of first birth. Of these mothers, 21 percent experienced two repeat pregnancies within this time period (Maynard & Rangarajan, 1994).

- The younger the adolescent female at first birth, the more likely she is to experience a repeat pregnancy within two years (Mott, 1986).

- Compared with teen mothers whose parents are high school drop-outs, teen mothers whose parents are high school graduates are less likely to have a second child within two years (Mott, 1986).

- Contrary to conventional wisdom, teen mothers who marry prior to first birth are more likely to have a child within two years than are their non-married counterparts, and are less likely to complete their education (Mott, 1986).

Why So Many Repeat Pregnancies to Teens?

The correlates of repeat pregnancies to adolescents are no different than those for first births: low socio-economic status, and accordingly, few educational and occupational aspirations. These problems are further compounded by the difficulties of becoming self-sufficient once a teenager has a child. Beyond the correlates of first births, however, other reasons emerge as important factors in repeat pregnancies to teens.

- Some teen mothers became pregnant in an effort to secure the lasting affection of a new boyfriend or even at a new boyfriend's request, to prove his manhood.

- Many repeat pregnancies occurred when a teen mother was experiencing a major transition in her life, suggesting that some of these women may have used pregnancy and childbearing as an unconscious means to avoid potentially stressful situations.

- Although many teen mothers reported contraceptive use, many became pregnant anyway, suggesting that these women need more attention with regard to incorporating regular contraceptive use into their daily schedule, and that contraceptive counseling efforts should be increased during periods of crisis and transition.

Implications for Effective Prevention

Based on the lessons from previous evaluations, implications for effective programs are as follows:

- In addition to finding jobs for young mothers, programs should focus equally on job retention.

- Provide additional educational support for teen mothers who attend high school and college, via peer counseling and educational tutoring.

- Provide ongoing contraceptive counseling to increase teen mothers' knowledge and ability to maintain consistent and effective contraceptive use.

- Provide high-quality, low-cost child care for teen mothers seeking economic self-sufficiency.

CONCLUSIONS AND POLICY AND PROGRAM OPTIONS

The Policy Roundtable Series covered four aspects of teenage pregnancy.

1. Developmental, environmental, and psycho-social correlates of teen pregnancy;
2. What is known about the effects of media on teenage risk-taking behavior (including sexual behavior) and how the media has been used to prevent adolescent pregnancy;
3. School- and community-based strategies to reduce teen pregnancy and the components found essential to the design of any such prevention program; and
4. Efforts to prevent repeat teenage pregnancies.

Definition of the Problem

How the problems of teen pregnancy is defined has significant implications for prevention. Whether the problem is defined as sexual activity too early, or sex in the absence of contraception, influences the prevention and interventions designed.

1. There is a need for consistency in how the problem of teenage pregnancy is defined. Programs need to be designed to be consistent with how the problem of teenage pregnancy has been defined.

2. Interventions should be based on how the problem is defined. These interventions must also be factually based and reflect what has been learned from research and the evaluations of prior prevention efforts.

3. Interventions need to be comprehensive and deliver consistent messages to teens in all aspects of their daily lives. The effectiveness of efforts by parents, schools, and others to tell children to remain abstinent clearly contradicts the strong messages delivered by television, movies, and other aspects of popular culture suggest otherwise.

4. A continuum of teenage pregnancy prevention messages should be consistent with the course of adolescents' developmental stage, promoting abstinence among children and young adolescents. Once teens are more likely to become sexually active, the message needs to shift to promoting responsible sexual behavior.

Serve Youth Comprehensively

Greater effort needs to be made to address issues like teenage pregnancy within the broader context of teen life. The risk for teenage pregnancy does not exist within a vacuum. Teenage pregnancy is but one form of increasingly common risk-taking behavior among today's

adolescents. Tobacco, alcohol, and drug use and violence are also often present in the lives of those youth most at risk of pregnancy, sexually transmitted diseases and AIDS. Most current efforts tend not to also address these other risks, be program-specific, or lack consideration of the impact of these other factors on the risk for pregnancy.

1. Because teen pregnancy does not exist independently of other youth concerns, interventions need to be comprehensive. The most effective interventions will not target teen pregnancy alone, but will address teen pregnancy as one of many risk-taking behaviors.

2. Prevention activities should take place over the course of childhood and adolescence.

3. Providers need to be trained to provide comprehensive services that address the rubric of teenage concerns.

4. Comprehensive interventions need to be tailored to the specific and unique needs of each community by people within the community who can speak to those needs. Avoid state imposition of prescriptive programs at the community level.

Involve Youth in the Program Development and Delivery

Too many interventions are designed by adults who are removed from the needs and realities of adolescents' lives.

1. Teenagers can participate in focus groups to inform age and culturally appropriate interventions, and to design media campaigns to change peer norms.

2. Youth can participate in teen pregnancy prevention as peer educators and role models to younger students.

School-Based Prevention

Currently school-based family life and sex education occurs sporadically. Little coordination exists between schools and social service agencies that provide or promote teen pregnancy prevention.

1. School-based family life and sex education curricula should be developed and implemented based on proven methodology and content, while also respectful of the standards of individual communities.

2. Educators need the opportunity and resources to learn the effective teaching methods for these topics.

3. School-based interventions which target teen pregnancy on an intermittence or sporadic basis are ineffective. Proven family life and sex education courses should be

part of the child's educational experience, beginning in elementary school and progressing through high school.

4. Schools should be encouraged to partner with local social and health service agencies to build upon the unique strengths and resources each can offer to the task of preventing teenage pregnancy.

Male Responsibility for Teenage Pregnancy Prevention

For every pregnancy and parenting teen mother there is a father. Much work needs to be undertaken to work with males to do their part in preventing teenage pregnancy. While the fathers of children born to teenagers are often adults, it is still appropriate to extend prevention efforts to male children and youth. And adult males need to better understand their responsibility for child rearing and support.

1. Target young boys and adolescent males and provide them with education that socializes them to have healthier attitudes towards women.

2. Provide older males with parenting skills and a sense of accountability to their children and the mothers of their children.

Violence Against Women

Violence against women has implications for male and female children alike in shaping their attitudes and behaviors in later life. Boys who grow up in climates of domestic violence may become socialized to accept violence against women as normal behavior. Girls who grow up in such climates may learn to see themselves as victims, thereby rendering themselves more vulnerable to teenage pregnancy.

1. Many teens become pregnant in an effort to get out of an abusive family setting or one that is imposed by the girl's partner who is trying to prove his manhood. These teens need safe shelters and other protective settings as an alternative to pregnancy.

2. Expand domestic violence efforts to include adolescents.

3. Provide increased protection services for teenage girls and women who report domestic abuse.

Sexual Abuse

Because so many teen mothers have a history of sexual abuse, an essential strategy to reducing teenage pregnancy rates requires addressing and preventing the problem of child and adolescent sexual abuse. Childhood sexual abuse among males may also play a significant role in this problem.

1. Service providers must be trained to identify, evaluate and treat child and adolescent sexual abuse.

2. Sexual abuse of both males and females needs to be examined and treated in order to socialize males and females towards healthier attitudes toward each other and toward sexuality.

3. Avoid enacting policies that isolate female youth who are suffering abuse at the hands of family members. There is little question that relationships between older men and younger teens may not be desirable or healthy. However, in some cases teens are seeking out adult age partners as a means for escaping an abusive family situation. Thus, prosecution of these relationships may have the adverse affect of forcing these teens to remain in the abusive family situations.

INTRODUCTION

Policymakers are increasingly concerned with the escalating incidence of teenage pregnancy and parenthood. There is a growing belief that teen pregnancy and childbearing is harmful for the individuals involved, the communities in which they reside, and for society in general. Teen pregnancy is perceived as having serious social and economic consequences at all these levels. It has been suggested that teen pregnancy leads to long term dependence on government programs like AFDC, and that teen parenting fosters a multi-generational legacy of poverty. Teen pregnancy also raises health issues for both the mother and infant. Some view teen pregnancy as a moral issue which may jeopardize the traditional family as an institution.

This briefing report was prepared for the California Family Impact Seminar (CAFIS) as a companion to the *CAFIS Teenage Pregnancy Prevention Policy Roundtables.* The report begins by describing the characteristics and trends of teen pregnancy in California (Chapter I). Chapter II outlines the developmental, environmental, and psycho-social correlates of teen pregnancy. Chapter III describes what is known about the effects of media on teenage sexual behavior and how the media might be used to prevent pregnancy. Chapter IV reviews school-and community-based teen pregnancy prevention strategies and describes the components found to be essential to the design of effective programs. Chapter V discusses the status of efforts to prevent repeat teenage pregnancies. Chapters II, III, IV, and V close with conclusions and policy and program options developed by Policy Roundtable speakers and participants. Finally, Chapter VI provides brief descriptions of key state teen pregnancy and parenthood programs.

CHAPTER I: TEENAGE PREGNANCY AND BIRTHS IN CALIFORNIA: TRENDS AND CHARACTERISTICS

Teenage Birthrates by Age

Birthrates increase steeply as teenagers get older, in large part because sexual activity increases. In addition, older adolescents are more likely to be fertile and to want to desire pregnancy.

- Birthrates among younger teens are relatively low—fewer than half of one percent of girls age 13 and 14 give birth annually, and roughly four percent of girls in the next age group, 15 - 17, become mothers. These rates are very similar in California and the United States.

- Among older teenagers (18-19), however, California's birthrates are somewhat higher than the rates experienced by 18-19 year olds throughout the nation.

Teenage Birthrates by Race/Ethnicity

Teenage birthrates in California, like those in the United States, also vary significantly by race and ethnic origin.

- Teenage birthrates to African Americans in California are somewhat lower than the national average, while teenage birthrates among Whites in California are nearly identical to the national average.

- In California, births to Hispanic teens are somewhat higher than the nationwide average birth rate for Hispanic teens. This is most likely due to the heavy concentration of Mexican origin Hispanics in California. The national average is based upon the birthrates of Hispanic teens from many different origins, including Cubans, who have relatively low birthrates compared to other Hispanic teenagers.

- In contrast, the teenage birthrate in Mexico is 94 births per 1000 teens, as compared with 117 births per 1000 Hispanic teens in California.

- It appears that in addition to cultural norms that value high and early fertility, Hispanic teens in California are faced with a variety of economic and social challenges that may leave them with fewer traditional restraints and little training or socialization in the skills necessary to become assertive or to negotiate within potential sexual relationships.

Birthrate Trends by Race/Ethnicity

Between 1980 and 1992, the birthrate in California increased by over one third—from 53 births per 1000 women ages 15-19 to 71 births per 1000 women in the same age group. Teenage birth rates for older teenagers are higher in California than in the United States.

This increase is due in part to the changing ethnic composition of California's population and to significant increases in the teenage birthrate among Hispanics and African Americans during the late 1980s and early 1990s. It is unknown whether this increase reflects rising pregnancy rates among teenagers, declining abortion rates, or some combination of the two.

- The birth rate for Hispanic teenagers in California is about three times higher than the rate for non-Hispanic White teenagers. This rate rose dramatically between 1980 and 1992—from 91 to 119 births per 1000 Hispanic women aged 15-19.

- The birth rate for African American teenagers in California also rose dramatically during this period—from 79 to 101 births per 1,000 African American women aged 15-19.
- The birth rate for non-Hispanic White teenagers in California rose only marginally between 1980 and 1992—from 34 to 38 births per 1000 White women aged 15-19.

Impact of Marriage on Teenage Birthrates by Race/Ethnicity

Within California, and the nation as a whole, variation in teen birthrates according to race or ethnicity of the teenager is a reflection of many different factors, including socioeconomic status, the age at which teenagers give birth, and the age at which teenagers marry.

- A much higher proportion of Hispanic teens are married than are either Black or White teenagers. At ages 18 and 19, 17 percent of Hispanic women versus 9 percent and 7 percent of White and Black teenagers respectively are married.

- Among Hispanic teenagers, more than among White or Black teenagers, a significant number of births are occurring to 15-17 year olds and especially 18-19 year olds within marriage.

Dimensions of Teenage Pregnancy

Teenage pregnancy is a growing American problem: with an estimated 1,000,000 teen pregnancies every year, the United States has the highest teen pregnancy rate of any industrialized nation (AGI, 1994). Approximately half of these pregnancies end in live births, while estimates hold that the other half end in abortion. Two thirds of estimated births to teens are to unwed mothers.

Teenage pregnancy does not equally affect all segments of the population. Low-income ethnic minorities are most likely to experience adolescent pregnancy and childbirth. Among actual births to teens, the non-marital birthrate is also much higher for African American adolescents than it is for White or Hispanic adolescents.

Any analysis of issues pertaining to teen pregnancy requires an examination of how developmental, environmental, and psychological issues impact adolescent sexual activity and contraceptive use, in order to determine which populations would most benefit from targeted interventions, and at what point such interventions might be most effective.

Socioeconomic Factors

The socioeconomic structure of society has changed drastically within the last few decades, impacting teenagers' sexual behavior. Increased violence and poverty across inner cities has brought instability to the lives of many adolescents. Poor teenagers, faced with few opportunities for achievement, are at high risk of becoming pregnant and/or parenting teens (AGI, 1994).

- Research indicates that sexual activity rates decrease as socioeconomic status increases, although not drastically. Between the ages of 15 to 17 years old, sixty percent of poor teens, 53 percent of low income teens, and 50 percent of high income teens become sexually active each year.

- Conversely, contraceptive use increases with socioeconomic status. Among 15 to 17 year olds, high income teenagers (83 percent) are more likely than low income teens (71 percent) or teens who live below the poverty level (78 percent) to use some method of contraception.

- Pregnancy outcomes also vary by socioeconomic status. Although 62 percent of youth grow up in higher income homes, only 17 percent of such youth become teenage parents. Conversely, while poor and low income youth constitute a lower percentage of all youth 15 to 17 years old, they comprise a much higher percentage of teen parents.

Race/Ethnicity Factors

Differences in teen pregnancy rates, teen birthrates, and teen abortion rates also vary according to the race and ethnicity of the teenager. Differences with regard to sexual activity across ethnic groups are not as large.

- Rates of sexual activity differ somewhat by the ethnicity of the adolescent girl. Among 15 to 17 year olds, Hispanic teens (49 percent) have the lowest rate of sexual activity, followed by White teens (52 percent), and Black teens (61 percent).

- Contraceptive use also varies by race. White teens are most likely to use contraception (81 percent). Seventy-seven percent and 65 percent of Black and Hispanic teens, respectively, report regular contraceptive use.

- Despite the lack of sizable differences between ethnic groups with regard to sexual activity and contraceptive use, pregnancy rates among 15 to 19 year old teenagers drastically differ by race. Black adolescent girls are most likely to get pregnant (19 percent), followed by Hispanic (13 percent) then White (8 percent) teens.

- Births to teens follow suit. Black female teenagers are also most likely to become adolescent parents, followed by Hispanic and then White teenage girls. This is most likely explained by cultural and religious differences with regard to abortion. White teens are most likely to abort, whereas Black and Hispanic teens are less likely to do so.

In conclusion, any comparison of the cultural patterns of White and Black groups should consider the strong effects of social class. When low-income Black families are compared to low-income White families (rather than a simple comparison of White families in general to Black families in general), most of the pregnancy and parenting trends commonly associated with race tend to disappear (Chilman, 1983).

Teen Fathers

Although most of the concern related to teen pregnancy focuses on teen mothers, teen fathers play a crucial role in adolescent sexual activity, pregnancy, and parenting. Seventy percent of fathers of children born to adolescents are over twenty years old. Thirty percent are still teens, although these teen fathers tend to be older than the mothers (AGI, 1994). Many fathers of children born to adolescent mothers share the same characteristics as the adolescent mothers:

- They grow up in poor families, often in single, female headed households.
- They are less likely to graduate from school on time.
- They are more likely to earn a GED than a high school diploma, thus severely limiting future earning ability.

Research has speculated that growing joblessness and relatively low earning power of black men, their higher rate of incarceration, and their high mortality rates contribute to the higher rate of non-marital teen births among African Americans (Wilson, 1987; Achatz, 1994).

Adult Fathers

A significant number of the males that father children born to teen women are adults. In 1993, two-thirds of the births of California's 47,000 school-age mothers were fathered by post-school-age fathers, aged 19 and older (Males, 1995). In 34.5 percent of these cases, the father was less

than a year older than the mother. However, in the remaining 65.5 percent of the cases, the father was an adult who was an average of five years older than the mother. For teens with adult male partners, the age difference was greatest for mothers 10-14 years of age (7.3 years) as compared with 17 and 18 year old mothers (4.9 years).

Little research has been published which examines why adult men become sexually involved with underage girls and father their children. There is a prevailing belief that adult men exploit teenage women by preying upon their emotional and financial needs. However, no research has been conducted that verifies this hypothesis. Clinicians who work with teen mothers and women who are at risk of becoming pregnant report that they choose adult men as sexual partners for several reasons:

- Teen women find adult men more desirable dates and sexual partners because these men are thought to be more mature and stable, offering the potential for long-lasting relationships;

- For many teen women, their relationship with a father or father figure lacks sufficient love, guidance, and support, which they seek from adult men through dating and sexual experiences;

- Some teen women believe that adult men are more likely to take responsibility for fathering a child and to marry, support, and/or care for the mother and child; and

- For teens who are in serious conflict with their parents or caretakers, relationships with adult men offer hope for a new and preferable living arrangement, and/or having a baby will offer them the opportunity for independence from the family of origin.

Sexual Abuse

Sexual abuse places many female adolescents at risk for teen pregnancy and parenthood. Some estimates hold that 65 percent of all teen mothers have been victims of sexual abuse, although the abuser is not usually the father of the child (Gershenson et al., 1989). Teenagers who have been sexually abused have earlier and higher rates of sexual activity than those who have not suffered sexual abuse. One study found that youth who were abused at earlier ages were most likely to experience teen pregnancy (Boyer & Fine, 1992). In addition, abused adolescents are more likely to have multiple sexual partners and engage in a wider range of sexual behaviors (Musick, 1993).

CHAPTER II: UNDERLYING DEVELOPMENTAL, ENVIRONMENTAL AND PSYCHO-SOCIAL ISSUES THAT LEAD TO TEENAGE PREGNANCY

There is no single cause of teenage pregnancy and as such, there is no single solution. In an attempt to clarify and define the problem, numerous studies have been undertaken to determine its correlates and antecedents.

A full understanding of adolescent pregnancy requires a complex, multi-layered view of the teen who becomes pregnant. Such a view encompasses adolescent development and the impact of the environment in which pregnant adolescents commonly reside.

Developmental Issues

Adolescence is an intense developmental phase during which a great number of changes can cause a great deal of stress and confusion. The adolescent phase of development entails changes in three major areas: physical, psycho-social, and cognitive. Each set of changes entails several tasks or challenges. Successful negotiation and accomplishment of these tasks and challenges allows the adolescent to become more comfortable with his or her emerging identity and self. The adolescent who does not successfully negotiate the tasks of adolescence, however, can become vulnerable to a number of adolescent problem behaviors, only one of which is adolescent pregnancy.

Physical Changes

Puberty begins the second major growth spurt in the life cycle. At age 12 and 1/2, the estimated average age of menstruation is the lowest it has been in the 20th century. With puberty, adolescents experience the onset of hormonal changes and the emergence of adult features. Throughout puberty, the adolescent must come to terms with new feelings and sensations, a new body image, self-consciousness, and awareness of guilt. Overcoming these challenges enables the adolescent to accept and be comfortable with her body, a task made even more difficult by the decreasing age at menarche.

What implications do physical changes hold for teenage pregnancy? Physically, girls at puberty are ready for sexual activity and pregnancy. Their hormones may even encourage it. Nonetheless, adolescent girls are neither cognitively nor emotionally prepared for sexual activity, pregnancy, or parenthood.

Physical changes also impact adolescent contraceptive use. Research indicates that self consciousness and guilt about sexuality impede adolescent females' contraceptive use (Furstenburg, et al., 1983). If this is the case, then pubertal adolescent females will be less likely to effectively utilize contraceptive methods. In fact, research has found that most adolescents wait an average of eleven months between initiation of sexual activity and obtaining birth control (Zabin & Clark, 1983).

Psycho-Social Changes

According to psycho-social theory, adolescence is a time of identity formation and consolidation (Erikson, 1968). In order to forge a sense of personal identity, the adolescent must accomplish a variety of tasks:

- Separate/individuate from parents. The teenager begins to partially but significantly withdraw from the emotional relationship with her parents. There is less dependence on parents and less acceptance of their emotional support. Parental influence on the adolescent's attitudes and values also decreases. Separation from parents can be facilitated by derogation of them.

- Define oneself in relation to the larger culture, thus emphasizing the increased importance of peer affiliation and approval. Adolescent peer relationships are vitally important for developing skills that lead to successful relationships in adulthood.

- Experience competency or achievement. Competency can be expressed through grades, sports, interpersonal skills, or other activities thought to be of value within the teen's community.

- Form a sense of sexual identity and learn to relate in a mature, intimate, and tender way towards others. This leads to sexual experimentation and later to intense emotional relationships with others.

- Develop a positive self-esteem, the capacity for liking and accepting oneself. Successful negotiation of the previous tasks also impact self-esteem.

Each of these tasks is vital to the development of identity. Adolescents who do not master these tasks will encounter self doubt as to personal and sexual identity issues. All kinds of problem behaviors - truancy, delinquency, substance abuse, or teen pregnancy - can occur as a result.

Early initiation of sexual activity can act as a means to form a sense of sexual identity or to define oneself in relation to the perceived demands of the peer culture. Teenage pregnancy and parenthood can provide a role or identity for adolescents who suffer such role confusion, or an experience of competency for adolescents who have no other means to do so.

Cognitive Changes

Cognitive changes in adolescence also impact issues associated with adolescent pregnancy. According to Piaget (1952), children demonstrate concrete operational thought, and are only able to entertain what exists in the present. The shift to formal operational thought occurs in adolescence, and means that hypothetical, or anticipatory events can be mentally represented or understood.

How does cognitive development effect adolescent pregnancy? In order to be able to anticipate sexual activity and evaluate its consequences, adolescents must have developed formal operational capabilities. Acquisition of these abilities, however, is influenced by an individual's environment,

culture, education, and personal experiences. In addition, if the childhood concrete phase of cognitive development endures into adolescence, teenagers can develop a personal fable of the self as different from all others, and unique and invulnerable. This "personal fable" is believed to account for so many teenagers' beliefs that they will not get pregnant, despite sexual activity in the absence of birth control.

To successfully forestall sexual activity, adolescents need to be able to anticipate situations that might lead to sexual activity. In addition, even if an adolescent female is able or willing to acknowledge the possibility of sexual involvement, she must also anticipate the consequences of sexual activity and undertake means by which to minimize the chance of pregnancy. Use of contraception is an unnatural process involving a number of cognitive steps:

- acknowledgment and acceptance of the decision to be sexually active;
- recognition of the possibility of pregnancy, including thinking about and discussing ways to prevent it;
- obtaining a contraceptive method; and
- keeping contraceptives available in situations when one might have intercourse, and using them whenever intercourse takes place.

Under normal circumstances, the possibilities for failure can occur at every step. Without adequate cognitive development, however, teenagers are even less able to anticipate sexual activity and to effectively use contraception.

Psycho-Social Issues

Psycho-social issues examine teenage pregnancy from a psychological perspective by attempting to explain adolescent girls' conscious and unconscious motivations to become pregnant. Such approaches assume that pregnant teenagers suffer personality or family deficits that explain the decision to engage in early pre-marital sex, to engage in early sexual activity in the absence of birth control, and/or to become pregnant. These deficits include:

- poor coping skills;
- emotional instability;
- external locus of control and a sense of powerlessness; and
- low self-esteem.

Poor Coping Skills

Research into the antecedents of teenage pregnancy (and other adolescent problem behaviors which include substance abuse, delinquency, and school drop-out) suggests that these problem behaviors may be a maladaptive method by which teenagers seek to cope with the transition to adulthood (Jessor & Jessor, 1977). In fact, research indicates that substance abuse, smoking, and early sexual activity are related. Early adoption of one of these 'adult' behaviors suggests that early adoption of the others is likely to ensue (Gibbs, 1982).

Emotional Instability

Emotional instability and unfulfilled or thwarted emotional needs explains why some teenage girls may engage in early sexual activity, refrain from contraceptive use, and become pregnant. Some research suggests that adolescent females who have strong dependency needs, desire affection, and are unhappy, are more likely to engage in early sexual activity and to become teen parents (Jessor & Jessor, 1977). Deficits in family relations may cause these needs and spur adolescent girls to engage in sexual activity and/or become pregnant to fill emotional gaps, rebel from overly strict parents, or get attention and love from indifferent parents.

External Locus of Control

External locus of control refers to a sense of powerlessness, an inability to exert control over the circumstances of one's life or one's environment. Girls who have this sense of powerlessness may become pregnant in attempt to experience a sense of mastery, as a mother, or conversely out of a sense of defeat. If one's social climate provides no aspirations, what reasons exist to forestall childbearing?

Low Self-Esteem

It has been suggested that adolescent females who become pregnant or parenting teens suffer from low self-esteem, and that lack of self-esteem propels teenage girls to seek love and affirmation via sexual activity and childbirth. For example, Ladner (1971) suggests that Black women have historically suffered a sense of low self-esteem, devalued first by White society, then by the Black male. However, there is no research to indicate that African American and Hispanic teenage girls, who have higher pregnancy rates, suffer lower self-esteem than do White adolescent females. Self-esteem should not be viewed as a personality deficit, but rather be examined in light of the historical and environmental circumstances that may foster it—poverty, racism, and other obstacles to mastery and achievement.

Environmental Issues

The female adolescent's environment also plays a crucial role in shaping her world view, and thus her likelihood of becoming pregnant. In numerous studies, poverty is the most salient correlate of adolescent pregnancy (Chilman, 1983; Gibbs, 1986; Hayes & Hofferth, 1987). Certain elements associated with poverty emerge again and again as the most important antecedents to teenage pregnancy. Specifically, girls who are at greater risk for adolescent pregnancy (Hayes & Hofferth, 1987; Zabin & Hayward, 1993):

- are the offspring of a teen mother and/or grow up in a single female headed household;
- attend racially isolated schools;
- live in neighborhoods in which teen pregnancy is common;
- have academic problems;
- have low educational and occupational goals;
- have dropped out of school;
- have more than five siblings;

- have parents who exercise lax control over dating; and
- initiate sexual activity early (and therefore use less birth control).

Inner-city neighborhoods, distinguished by poverty and often populated by low-income ethnic minorities, are characterized by many of the previous descriptions.

Policy intervention opportunities parallel the three general at-risk categories: education, aspirations, and neighborhood.

Education

If girls who have academic problems or drop out of school are more likely to become pregnant, these girls can be targeted early on for educational assistance. Schools can provide these students with individual attention and academic assistance to foster academic success. This success plays into developmental considerations as well. If competence and mastery are vital parts of successful identity development, then schools can provide an arena in which competence and mastery can be attained.

Aspirations

Teenage girls are more likely to become pregnant if they lack educational and occupational goals. Decision-making theory suggests that adolescents actively decide whether or not to have sex and risk pregnancy by weighing the costs and benefits of the alternatives. Thus, before engaging in sexual activity, adolescents weigh the probability and significance of out of wedlock birth, and the loss of opportunity for educational, occupational, and marital goals. If this is true, the weight of these factors must be considered with respect to differences among ethnic and socio-economic groups.

For upper class adolescents, educational and occupational goals are high and teenage pregnancy is stigmatized. The relatively high abortion rate among pregnant higher income adolescents may indicate that these pregnant teens have a reason to forestall parenthood beyond adolescence. Conversely, the relatively high teen pregnancy rate and low abortion rate among lower income adolescents may point to cultural differences, or may reflect the fact that teenage parenthood does not significantly impact poor adolescents' educational and occupational goals, which are already low.

Providing adolescent females (and males) with educational and occupational aspirations requires profound changes within the educational and economic structure of society. Teenagers need to sense that they can achieve more without a baby, that education leads to employment, and that employment can be financially and emotionally rewarding.

Neighborhood

Research suggests that one's physical environment shapes one's view of the world (Wilson, 1987). Adolescents who grow up in climates of poverty, where family members, friends, and acquaintances commonly bear children in adolescence, will be shaped by that reality and will see

teenage pregnancy and parenthood as the norm, at best unstigmatized, at worst, something to achieve. Socio-economic and racial isolation exacerbate this set of circumstances, as teenage girls have little exposure to an alternative economic and social reality: one where parenthood is forestalled in the hopes of a brighter educational and occupational future.

Balkanization of ghetto neighborhoods and the absence of middle class African American and Hispanic role models and mentors also makes it difficult for low-income adolescent females to see a path out of poverty which offers an alternative to the rampant teenage pregnancy around them. Social isolation, of course, is most difficult to impact via policy. Mentoring and opportunities to experience other realities can make a difference.

ROUNDTABLE CONCLUSIONS AND POLICY AND PROGRAM OPTIONS

Participants in the roundtable highlighted the following issues for special concern and offered suggestions as to how to respond to these concerns.

How Do We Define the Problem of Teen Pregnancy?

How we define teen pregnancy drives the policy we use to combat it. When teen pregnancy is defined as a problem of values (i.e., too many children are engaging in too early sexual activity), we send abstinence programs to forestall sexual activity. When the problem is defined as teenage parenthood, we provide contraceptive education and access. If we define teenage pregnancy as a symptom of a larger problem (i.e., lack of options), then the larger problem needs to be addressed.

Policy and Program Options

Teenage pregnancy is a complicated issue, and as such, there is no one way, or no right way to address it. But we must be certain of how we are defining the problem before we design campaigns to address it.

1. Interventions should be based on how the problem is defined. These interventions must also be factually based and reflect what has been learned from research and the evaluations of prior prevention efforts.

2. There is also a need for interventions that are comprehensive and deliver consistent messages to teens in all aspects of their daily lives. The effectiveness of efforts by parents, schools, and others to tell children to remain abstinent clearly contradicts the strong messages delivered by television, movies, and other aspects of popular culture suggest otherwise.

Serve Youth Comprehensively

Greater effort needs to be made to address issues like teenage pregnancy within the broader context of teen life. The risk for teenage pregnancy does not exist within a vacuum. Teenage pregnancy is but one form of increasingly common risk-taking behavior among today's

adolescents. Tobacco, alcohol, and drug use and violence are also often present in the lives of those youth most at risk of pregnancy. Most current efforts tend not to also address these other risks, be program-specific, or lack consideration of the impact of these other factors on the risk for pregnancy.

Policy and Program Options

Interventions need to be more comprehensive, addressing sexuality, AIDS, violence, substance abuse, and whatever other issues are adversely affecting or of concern to adolescents.

1. Because teen pregnancy does not exist independently of other youth concerns, interventions need to be comprehensive. The most effective interventions will not target teen pregnancy alone, but will address teen pregnancy as one of many risk-taking behaviors.

2. Prevention activities should take place over the course of childhood and adolescence.

Lack of Options

Teenage girls who become parents often do so because they have fewer options than their non-parenting peers. Schools and occupational opportunities in inner-city neighborhoods are not as strong, and, consequently, expectations for success within inner-city communities are not as high. As a result, adolescent males who grow up in such communities feel unsuccessful, and adolescent females lack aspirations, providing a perfect opportunity for adolescent pregnancy to occur.

In addition, because so many teenage females are victims of abuse, either in their homes or in their relationships, these girls are much more vulnerable to adolescent pregnancy as an escape from what can be a unhealthy lack of options.

Policy and Program Options

The task is to create an environment in which teens feel they have options beyond pregnancy and parenting.

1. Because communities across California vary across such a broad range, interventions need to be community based and community specific to impact the needs of each community. That is, community agencies or schools that implement state-wide interventions need the latitude to tailor these initiatives to meet their community's specific and unique needs.

2. Provide shelters and safe settings for teenage girls who are victims of abuse, either by their families or by their partners as an alternative to pregnancy.

Effects of Domestic and Social Violence on Teen Pregnancy

Domestic violence is intrinsically linked to teen pregnancy because of its effects on the development of male and female socialization patterns and the intergenerational transmission and

trends of teen pregnancy. Children who witness domestic violence in their home will become shaped by their exposure. Boys will have only violent and abusive behavior to model, while girls will perceive their role as that of victim.

Policy and Program Options

Because domestic violence does not get reported nearly as often as it occurs, we need to increase efforts to identify domestic violence and provide protection and services, and extend these efforts to teenage women.

Older Men/Younger Mothers

Why do so many "older" men (men in their late teens and early twenties) impregnate younger women? It is important not to focus on chronological age. Because of limited life circumstances, so many of these men are stalled at an adolescent developmental stage and the only way to exert mastery and control over their lives is by controlling younger women. In addition, sex role socialization provides a definition of manhood that is counterproductive to fatherhood: being a man means having a lot of children, but being a good father is not part of this definition.

Policy and Program Options

Because most fathers of children born to teen mothers are "older", something must be done to target these men as well as the women who bear their children. Or, as one roundtable attendee stated, pregnancy prevention campaigns must reach the victims, the perpetrators, and the witnesses.

1. Target 12-13 year old boys with programs that socialize them towards healthier attitudes towards fatherhood.

2. Address older male teens with interventions that provide them with a sense of accountability to their children, as well as to the mother of their children.

3. Reach "older" males and provide them with parenting skills.

Social violence, or violence that is an every day part of inner-city residents' lives, also has a profound impact on the behaviors of those exposed, particularly children and adolescents. There is a need to examine the link between exposure to community violence and its impact on adolescent behavior such as teen pregnancy.

Involve Youth in the Program Development and Delivery

Youth should be involved in the design and implementation of prevention strategies. Youth have a valuable role to play in these efforts. Talk to teenagers to learn their concerns and suggestions for what interventions might work and how they might be best implemented.

Policy and Program Options

There are several ways to involve youth in designing and implementing prevention strategies.

1. Teenagers can participate in focus groups to inform age and culturally appropriate interventions, and to design media campaigns to change peer norms.

2. Use peer educators to deliver interventions, thus providing younger teens with role models they can relate to.

3. Use milieus such as teen theater to present the teen experience.

CHAPTER III: TEENAGE PREGNANCY AND THE MEDIA

Effects of Media on Teenage Sexuality

Television, movies, and music videos viewed by adolescents do not shy away from sexuality, yet their depictions of sexuality are often unrealistic, portraying the glamorous side of sexuality but ignoring the possible consequences: unintended pregnancy and sexually transmitted diseases. Since television may be the only source of information about sexuality, birth control, and sexually transmitted diseases, for many teenagers, the consequences of such unrealistic portrayals can be extremely negative.

Access to Television

Adolescents have easy access to television. Despite differences in socioeconomic levels, family ownership of televisions is nearly universal. By the mid 1980s, almost fifty percent of all American homes had cable television and nearly one third had at least one VCR. The same study found that adolescents watched 5 to 8.5 hours of television every weekday (Brown, Childers, Bowman, & Koch, 1990). By the time he or she graduates from high school, the average American teenager will have spent 15,000 hours in front of the television but only 11,000 hours in formal classroom instruction (Strasburger, 1985).

Sex and Television Content

Sex is a considerable part of television content. In all program categories, unmarried heterosexual couples engage in sexual intercourse from four to eight times more frequently than married men and women. Contraceptives are almost never referred to or used, but women seldom get pregnant. Men and women rarely contract sexually transmitted diseases unless they are prostitutes or homosexuals (Greenberg, Graef, Collado-Fernandez, et al., 1980). In action and adventure shows, heterosexual sex is often associated with violence or a display of power, and is rarely depicted in the context of a loving or committed relationship or as an expression of mutual affection (Sprafkin & Silverman, 1981).

American teenagers view nearly 14,000 instances of sexual material on TV each year. Of these 14,000 sexual references on television, only 165 refer to topics such as sex education, sexually transmitted diseases, birth control, or abortion. This represents a ratio of about 1 to 85 (Harris, 1988).

- Soap operas contain an average of 35 instances of sexual content per hour, or more than one instance of sexual intercourse every two minutes (Harris, 1988).

- Content analysis of a one-year study period revealed no commercial advertising for any birth control product and no Public Service Announcements (PSAs) about family planning and safe sex practices (Harris, 1988).

Impact of Television, Movies and Music Videos on Teenage Sexual Attitudes and Behavior

Studies show that television, movies, and music videos can have a negative impact on adolescents' perceptions about sex, attitudes towards sexuality, and sexual behavior.

- In a study of adolescent girls, pregnant unmarried females were twice as likely as never pregnant girls to say that heterosexual relationships on television are similar to real-life relationships, and to predict that their favorite TV character would not use birth control if involved in a pre-marital sexual relationship.

- A study of 400 junior high school students found that those who were heavy viewers of "sexy" television were more likely than light viewers to have become sexually active during the year prior to the survey (Newcomer & Brown, 1984).

- In this same study, adolescents also reported that television is equally or more encouraging about sex than either their best female or male friend.

- A 1987 analysis of movie and television content found that the average rate of sexual acts and references in R-rated movies was about seven times higher than it was in prime time commercial television. Movie characters were even more likely than television characters to respond to sex. In addition, visual depictions of sex were more common in movies than on television (Greenberg, Linsgowan, Soderman, 1987).

- College females who watched a greater amount of sexually suggestive music videos on MTV had more permissive attitudes about sex than did light viewers (Strouse & Buerkel-Rothfuss, 1987).

Media Campaigns to Change Adolescent Behavior

Given the strength and frequency of television and movies' impact on adolescents, it is difficult to imagine what types of messages could work as an effective counterbalance. As of yet, few media campaigns have tried to affect adolescent health behaviors. Even fewer campaigns have been evaluated to determine the degree to which media positively impacts adolescent sexual behavior. One media campaign that targeted smoking by teenagers has been found successful. Teenage pregnancy prevention campaigns have yet to be evaluated.

Elements of Media Campaigns

Media campaigns to impact social problems such as smoking, AIDS, poor cardiovascular health, and teenage pregnancy can use any or all of the following common elements:

- Public Service Announcements (PSAs);
- Radio advertisements or PSAs;
- Television advertisements or PSAs;
- Newspaper or magazine advertisements; and
- Flier or leaflet distribution.

Evaluation of Media Campaigns

As difficult and costly as it may be to implement media interventions, evaluation of media campaigns is even more difficult. Media campaigns do not exist in a vacuum. Adolescents who see PSAs also view myriad contradictory messages on television and in their daily experiences. In addition, they receive other messages from educational curricula designed to impact the same behaviors. As such, it is extremely difficult, if not impossible, to isolate and determine the effects of a media campaign on adolescent behavior.

Salmon and Johnson (1991) outline the few questions that evaluation can adequately answer, and the different processes that are used to determine how media campaigns can be most effective.

- ***Formative evaluation*** can be used to determine what campaign components work best. Formative evaluation consists of concept testing messages in focus groups and by use of surveys, to determine which messages are best received and which have unintended consequences.

- ***Efficacy evaluation*** attempts to determine whether the campaign can expect to make a difference under optimal conditions. Using quasi-experimental trials over several months, media messages are given to different target audiences in controlled settings. Audiences are surveyed following receipt of the media trials, thereby checking the generalizability of the campaign to different parts of the community.

- ***Process evaluation*** identifies which materials are disseminated throughout the course of a media campaign, and who receives which materials. This can be accomplished by telephone survey, enumeration of calls to local hotlines listed as referral sources following media attention, and use of Broadcast Advertising Reports to determine estimated audiences for each media spot. Because these methods vary with regard to their obtrusiveness, and thus their accuracy, the authors recommend using all three.

- ***Outcome evaluation*** of the ultimate effectiveness of a media campaign is the most difficult to accomplish for several reasons. First, it is impossible to isolate the effects of a media campaign from the influences of television, movies, education, community, and family. Even if this isolation were possible, evaluations of most media campaigns do not compare a treatment group who received the campaign to a comparable control group that did not. The authors suggest overcoming these difficulties by inclusion, if possible, of a comparable control group, thereby ensuring that both treatment and controls will have been exposed to similar outside influences.

A Successful Anti-Smoking Campaign

Flynn, et al. (1992) evaluated a campaign to prevent cigarette smoking through a mass media intervention combined with school-based educational curricula. The campaign was delivered and evaluated over four years to two cohorts of students: one in Montana and one in a North Eastern community. Each treatment cohort was matched with a control cohort that received the educational curriculum, but no media intervention. The students were given baseline surveys in

grades 4, 5, or 6, and then surveyed again once every year for the next four years to determine changes in their smoking behavior.

Students in the treatment groups were exposed to frequent and varied television and radio spots that aimed to provide them with:

- a more positive view of non-smoking;
- a more negative view of smoking;
- improved skills to refuse cigarettes; and
- a better understanding that most kids their age don't smoke.

The educational curricula received by the students over the same four-year period echoed these goals. Findings indicated that cigarette smoking increased less among the adolescents who received the mass media intervention combined with the school smoking prevention curriculum than it did among the adolescents in the control group who only received the school program.

Based on their findings, the authors made the following recommendations for implementation and evaluation of media campaigns:

- make sure that media interventions are coordinated with school curricula;
- use diagnostic and formative research to ensure that message styles work and apply to all targeted age groups; and
- air a variety of advertisements frequently.

Effects of other Media Campaigns

Research has demonstrated that media campaigns can influence changes in knowledge, attitudes, and beliefs. However, when not conducted in concert with other prevention strategies, media interventions do not significantly impact behavior (Flay, 1989; McAlister, et al., 1989; Rice & Atkin, 1989). This may be due to difficulties in isolating the effects of media interventions, or the fact that adolescents are a particularly difficult population to impact by use of media alone. It is important to consider these issues with regard to sexuality and teenage pregnancy, because while media campaigns aimed at improving cardiovascular and general health may demonstrate some success (Farquhar, et al., 1985; Wagner, et al., 1991), adults may respond very differently to media than do teens.

In addition, teen pregnancy and sexual activity may be more difficult to impact than other public health concerns. Teenage pregnancy as related to teenage sexual activity is a private behavior. That is, unlike smoking, it occurs in a non-public arena, and thus may be less susceptible to influence. With regard to teenage pregnancy, media campaigns can attempt to curb teenage pregnancy in several ways:

- providing knowledge and resources about contraceptive methods;
- providing referral sources for family planning clinics;
- encouraging adolescents to use contraceptive methods; and

- changing social norms around adolescent sexual activity and contraceptive use, thereby providing teenagers with the sense that not all teenagers have sex, and teenagers that are sexually active should and do use contraception.

To date, only one teenage pregnancy prevention program, Education Now And Babies Later (ENABL), California's abstinence-based program targeting 12 to 14 year olds, has used a mass media campaign combined with an educational intervention to seek to reduce adolescent pregnancy. Results of the effectiveness of this campaign are pending.

ROUNDTABLE CONCLUSIONS AND POLICY AND PROGRAM OPTIONS

Participants in the roundtable discussed the issues of placement, content, and implementation of media campaigns.

Placement of Media Campaigns

Production and placement of messages is critical. Media campaigns should be creative enough to stop people from switching stations. In addition, television should not be the only medium by which to reach teenagers.

Policy and Program Options

Create an individual flavor for a media campaign and encourage creativity. Avoid clutter of too many advertisements at one time or overuse of a single message by:

1. using different advertising or PR firms;

2. using different media options such as video games, internet, radio, or print; and

3. using different mediums for different types of messages. For instance, it may be more economically feasible to develop long PSAs depicting teen parenting scenarios for radio spots than for television.

Content of Media Campaigns

Due to the competing interests and values of policymakers, program directors, and parents, there is no way to keep everybody happy when designing a media campaign. Bear in mind, however, that this is not the goal. The target audience—teenagers—should always be in focus.

Policy and Program Options

Youth do not want to be told how things are. They would rather see behaviors modeled for them. In a media campaign to curb teen pregnancy, it is recommended that the messages depict more about the quality and depth of what teen parenting looks like.

In addition, denormalize teen pregnancy in the same way that anti-smoking campaigns denormalized smoking. Here are some suggested approaches to social marketing.

1. Begin by changing perceptions of the environment, so teenagers can see the issue differently.

2. Counter positive messages about teen pregnancy with alternative messages such as, it's okay to say no.

3. Change community norms by shifting the paradigm to responsibility. For example, is it responsible to bring a child into the world when you don't have a job?

4. Change the way people think about what they see on the media. For example, after a made-for-TV movie or sitcom, run a 30 second spot asking viewers how the program will affect their lives or what they thought about the characters' motivations. Provide some discussion-provoking questions or statements. Help viewers focus attention on what they just saw.

Finally, it is impossible to know what messages are out there without actually speaking to teenagers. Testing messages in teenage focus groups is an indispensable part of the process.

Mixed Messages

Roundtable members expressed concern with regard to sending mixed messages about abstinence and contraception. Is it possible to have conflicting messages together? Can we talk about abstinence and birth control at the same time?

Policy and Program Options

Some people can hear messages at once and assimilate the information; others cannot. But it is important to remember that adolescents are the audience, and adolescent sexual development occurs on a continuum. Reach young children before they become sexually active with messages aimed at delaying the onset of their sexual activity. As they grow older and become sexually active, however, these same youth need to receive an additional message: here is how you protect yourself and engage in sexual behavior responsibly.

Political Considerations

Using media campaigns is more difficult when a political agenda is attached to it. In addition, available funding defines the strategies used. With the introduction of public funds, accountability becomes an issue.

Policy and Program Options

In creating a media campaign aimed at changing behavior, be aware of the conflict inherent in the process of White, middle class men and women developing strategies that are supposed to appeal to and impact youth. Again, political agendas should not apply.

1. The target audience is youth, and a successful media campaign will aim to encourage healthy behaviors, not impose middle class values.

2. Any media campaign strategy should include plans for policy change at the legislative level. For example, the California anti-tobacco media campaign was successful not only because it changed public norms about behavior, but because changing these norms allowed for the passing of very restrictive anti-smoking laws.

3. Public-private media partnerships might work best. Private sector fundraising skills are not to be ignored, and combination of the two sectors might curb political agendas while capitalizing on the expertise among personnel at the state level.

CHAPTER IV: SCHOOL- AND COMMUNITY-BASED TEENAGE PREGNANCY PREVENTION STRATEGIES

There are three major approaches to prevention of adolescent pregnancy: (1) persuade children and adolescents who have not yet had sex to delay sexual activity; (2) for adolescents who have had sex, increase contraceptive use; and (3) provide meaningful alternatives to adolescent parenthood. Each of these approaches can be initiated via schools, community-based organizations, or a combination of both. The following summary outlines what has been done in each of these realms, and reports on the effectiveness of interventions with regard to teen pregnancy reduction in the past twenty years.

Delaying Sexual Activity

Abstinence education programs seek to delay the onset of sexual activity among adolescent or preadolescent youth. Abstinence approaches are based on compelling data, indicating that teen pregnancy rates are highly and positively correlated with onset of sexual activity. Abstinence programs usually focus on the importance of abstinence until marriage. Typically, abstinence programs provide two types of education, although the two are not mutually exclusive. The first program type is knowledge based, providing basic information on reproduction and values and ethics. The second program type provides youth with decision making skills, assertiveness training, and skills to respond to the pressures to have sex. Abstinence programs either do not discuss contraception, or do so only briefly, to convey the failure of contraception to provide complete protection against pregnancy and STDs.

Knowledge Based Education

Evaluations of knowledge based abstinence curricula have found increases in students' knowledge and tolerance for attitudes of other youth, but no changes in their own attitudes toward sexual activity (Kirby, 1984). Other evaluations suggest that this type of abstinence education alone has little influence on adolescent sexual behavior (Zelnick & Kim, 1982; Kirby, 1994).

Assertiveness and Decision-Making Skills Training

To date, only three studies of school-based programs that focus on assertiveness and decision-making skills training have been evaluated and published in professional literature. Although findings have not demonstrated success of abstinence curricula, limitations exist as to the validity and generalizability of the findings. A large scale, rigorous evaluation of abstinence-based curriculum is currently under review.

Project Taking Charge. Jorgenson, Potts, and Camp (1993) evaluated Project Taking Charge, a school-based abstinence program implemented in 30 home economics classes over the course of a six week period. The program was delivered to students in Wilmington, Delaware, and West Point, Maryland. Both of these communities are relatively low-income and have high rates of adolescent pregnancy. The classroom component covered instruction on self-development, anatomy and physiology, pregnancy, STDs, the importance of abstinence prior to marriage, vocational goal setting, family values, and family communications. In addition, three classes

included communication exercises, values exploration, and instruction on adolescent sexuality, pregnancy, and STDs. At six month follow up, no significant differences existed between treatment and control groups with regard to initiation of sexual intercourse. The small sample size (n=91) limits the generalizability of these findings.

Success Express. Success Express was implemented and evaluated twice to determine its effectiveness with regard to delaying the initiation of sexual intercourse (Christopher & Roosa, 1990; Roosa & Christopher, 1990). Both times, the program was implemented in health education classes in five schools to low-income, high-risk, sixth and seventh graders. The curriculum covered abstinence attitudes, skills, and behaviors, self-esteem, family values, peer and media pressures, consequences of sex, how to say no to sex, life goals, and goal setting skills. Students were surveyed prior to receiving the curriculum, then six weeks later. The survey found no significant changes in delay of sexual intercourse, or on other measures. The post-test period of six weeks did not allow sufficient time for a measurable delay in the initiation of intercourse. Further long term analysis was not undertaken because no differences on any other measures were found between treatment and control groups in the initial post-test period.

Postponing Sexual Involvement (PSI). PSI was first delivered with two components: a five hour human sexuality unit that included information on reproduction, contraception, and decision making, and a five hour unit to help youth understand social and peer pressures to have sex and to develop and apply resistance skills. The curriculum was delivered by eleventh and twelfth grade teenagers to 536 low-income, Black eighth graders whose parents attended a public hospital.

The PSI curriculum has currently been delivered throughout California, minus the five-hour human sexuality unit. That is, it has been abridged and transformed into a purely abstinence-based curriculum. Students have received a five hour unit on decision making skills, social and peer pressures to have sex, and assertiveness skills to resist sex, but no information on human sexuality or contraception. In addition, the curriculum was delivered in some areas by peers, and in some areas by adults. Evaluation results are pending and eagerly awaited.

Increasing Contraceptive Use

Most research to date has focused on the effectiveness of promoting contraceptive use in preventing teenage pregnancy. Research shows that, on average, a teen will not begin using contraceptives until eleven months after beginning to have sex. Sex education and provision of family planning services are the two types of programs traditionally aimed to improve contraceptive use within this population. Both approaches can be provided in schools or community settings. While both approaches can also be combined (i.e., in school-based family planning clinics), they will be considered separately in this document.

Sex Education Approaches

Sex education programs differ from abstinence programs in that they discuss both contraception and, possibly, abstinence. Sex education programs typically seek to forestall the onset of sexual activity among those teenagers who are still virgins, while encouraging teenagers who are sexually active to use contraception.

Two methods exist by which to evaluate the impact of sex education programs on adolescent contraceptive use and sexual behaviors.

- Studies based upon large, nationally represented surveys of adolescent youth include retrospective questions about participation in sex education programs and about personal sexual behavior.

- Specific educational programs are evaluated with experimental or quasi-experimental designs, assigning students to treatment and control groups and evaluating the success of interventions' specific goals.

National surveys of adolescent youth. Studies of sex education and assertiveness training programs to increase adolescent contraceptive use based upon large nationally representative surveys have found mixed results. Kirby (1984) found very few impacts of sex education on contraceptive use. Dawson (1986) found evidence that teenagers who had a sex education course were more likely to use contraception at first intercourse. Marsiglio and Mott (1986) reported that teenagers who had sex education were more likely to use contraception at age 17 or 18. Eisen (1988) found that students who received a standard sex education course and those who received a sex education course with assertiveness training were equally likely to increase contraceptive knowledge and use one year later. This suggests that, while assertiveness training is useful in encouraging contraceptive use, it is no more useful than standard sex education training.

Specific educational curricula. Kirby et al. (1994) evaluated eight school-based programs to increase contraceptive use. Although all eight programs varied with regard to specific treatment goals, intervention components, target populations, and locations across the country, all eight did include measurement of the program's impact on contraceptive use. Data from all eight studies indicate that some of the programs increased contraceptive use. In two studies, contraceptive use increased among all sexually experienced youth. In two other studies, contraceptive use increased among specific groups of students. As a result of this analysis, Kirby et al. (1994) suggest that successful programs should share the following distinguishing features.

- Focus on a few specific behavioral goals, such as using contraception or delaying sexual initiation, and spend relatively little time on other more general issues such as gender roles or self-esteem.

- Use social learning theories as a basis for programs. Social learning theory suggests that in order for adolescents to effectively use contraception, they must have the knowledge to do so, must believe that pregnancy is worthwhile to avoid, must believe that contraception will in fact prevent pregnancy, and must believe that they have the ability to use contraception effectively. Social learning theory also suggests that adolescents gain these beliefs from education as well as observation and practice of the desired behaviors.

- Provide information about the risks of unprotected intercourse and ways to avoid unprotected intercourse by using experiential activities to personalize this information.

- Include activities that address media and social impact on sexuality.

- Discuss and strengthen individual values and group norms that counter unprotected sex.

- Provide exercises and activities in which students can model and practice communication and negotiation skills.

- Provide training for individuals implementing the programs.

Family Planning Services

Provision of family planning services can take place at clinics located within schools or linked to schools. These clinics also vary by the services they provide. Some clinics only provide reproductive health services while others provide comprehensive health services including adolescent reproductive health. While results of these programs are inconsistent, they clearly indicate that provision of reproductive health services on or nearby school campuses does not hasten the onset of sexual activity, nor does it increase its frequency.

Self Center, Baltimore, MD. The Self Center, an adolescent reproductive health clinic located across the street from a high school and four blocks away from a junior high, provided education, counseling, and reproductive health services (including contraceptive dissemination) to students at both schools. Survey data was collected from the program and comparison schools. Results indicate that there was a delay in the onset of sexual activity among those youth who had not yet initiated sex, and that sexually active students who attended the treatment schools increased their contraceptive use. In addition, two years following the program, there was a large decrease in pregnancy rates among the students in the treatment schools. The authors concluded that the greatest program effects occurred for younger teens who stayed in the program the longest and developed new patterns of knowledge and behavior (Zabin, et al., 1986).

Six School-Based Comprehensive Health Clinics. Kirby, Waszak, and Ziegler (1991) evaluated six school-based comprehensive health clinics on six school campuses in different parts of the country. The clinics varied by the extent to which they provided reproductive health services: two clinics referred students to other clinics for contraceptive services, one clinic provided prescriptions, and three clinics actually dispensed contraceptives. The manner of their educational programs also varied by site. Findings indicate that, while none of the programs affected the onset of sexual activity or pregnancy rates in any of the schools, some programs (particularly the programs that dispensed birth control) affected positive changes in contraceptive use.

Providing Meaningful Alternatives to Adolescent Parenthood

It is well established that adolescent pregnancy is more prevalent among teenagers who grow up in climates of generational poverty (Chilman, 1983). Teens who have low grades and few aspirations are less likely to delay sexual intercourse and become adolescent parents (Hayes & Hofferth, 1987). Consequently, it has been hypothesized that providing teens with ambition, plans for the future, and educational and occupational opportunities to achieve might provide them reason and means to avoid adolescent pregnancy.

Life options programs seek to provide meaningful alternatives for teenagers who have fewer opportunities for a productive life. Rather than targeting adolescent sexual activity or teen

pregnancy alone, life options programs focus on occupational opportunities and/or life management skills that encourage adolescents to set and achieve goals for their lives. Additional program goals may include reductions in school drop-out, school failure, substance abuse, delinquency, and other problem behaviors commonly associated with teen pregnancy and assumed to be correlated with lack of options and stifled aspirations.

The Teen Outreach Program (TOP) has targeted both younger and older teens in a variety of socioeconomic settings with populations of various races and ethnicities. Small groups of 15-20 TOP students meet once a week in a mutually supportive atmosphere, facilitated by a caring and trained adult who is a friend and mentor rather than an authority figure. The program includes its own curriculum, engaging students in discussions of topics such as understanding themselves and their values, cultural diversity and acceptance of differences, goal setting, decision-making, problem solving, human growth and development, parenting, family relationships and community resources. Students must participate at least one hour per week in a volunteer program. Extensive evaluations of the program over its ten-plus year history have included three years of random sampling with 472 Teen Outreach students and 496 control group students (Allen and Hoggson 1990; Allen and Philliber 1991).

In comparison to students not participating in TOP, TOP students have shown:

- A 32 percent lower rate of course failure in school;
- A 37 percent lower rate of school suspension;
- A 43 percent lower rate of pregnancy; and
- A 75 percent lower rate of school dropout.

These results are not affected by the student's race, gender, or grade, their mother’s education, family living arrangement or other pre-program indicators.

The Perry Preschool in Michigan is an early intervention program that served as a model for the federal Head Start program. There are both similarities and differences between Head Start and Perry Preschool. The Perry Preschool targeted children from low-income families and low parental educational attainment. It included a 5- or 6-to-1 child-teacher ratio and well-trained and well-paid teachers. The curriculum has evolved over time, emphasizing creativity development and individual decision-making at age-specific developmental levels. The children attend morning classroom sessions and are visited at home each afternoon for a total of one and a half hours each week. Parents also attend regular meetings.

The Perry Preschool evaluators followed the initial students for twenty years. As compared with a control group, these children were more successful in school, performed at a higher scholastic level, received greater recognition, and were less often placed in special education programs. Increased earnings, reduced welfare, and reduced crime have also been carefully documented results of the Perry Preschool. Of special interest is the reduction in births to female participants who experienced half as many teen births as the comparison group. While the program is expensive, the initial cost is outweighed by the later benefits gained by the individual and society (Barnett 1985).

ROUNDTABLE CONCLUSIONS AND POLICY AND PROGRAM OPTIONS

Discussion at this roundtable focused on ways to integrate research and evaluation with effective interventions that target specific groups of youth and the need for systematic changes within the public school system.

What is Appropriate Sexual Behavior and Expression?

As a society we are unable to answer this question. As a result, we send our children mixed messages at home, in school, and in the media. Due in part to political partisanship, pregnancy prevention programs received by today's youth embody too many conflicting values that are delivered at inappropriate times and to inappropriate populations. For instance, despite the fact that many middle school age youth in urban areas of California have already initiated sexual activity and are getting pregnant, abstinence programs are being delivered when contraceptive education would be more appropriate.

Policy and Program Options

Policymakers need to be informed of the most current research on pregnancy prevention. Large scale pregnancy prevention programs should be appropriate; that is, designed to best serve specific developmental or demographic populations.

Systematic Approach to Preventing Teenage Pregnancy

Sexuality is too complicated to boil down to one teenage pregnancy prevention model. It would be a mistake to try to come up with a single prevention program. There are multiple ways to promote healthy behaviors, and different programs will work with different kids. Thus what would be most effective would be a systematic approach that takes a bio-psycho-social perspective, entertaining all aspects of the teenager's world, and combining all adults who impact adolescents' lives.

Policy and Program Options

The following recommendations were generated to address the need for a systematic approach to preventing adolescent pregnancy.

1. Because teenagers interact with adults in many different realms (parents, teachers, social workers, school nurses, juvenile justice workers), these professionals need to come together to design integrated curricula that addresses the teenager's biological, psychological, and social needs during each phase of development.

2. Because these adults all serve adolescent youth in different capacities, they need to be cross-trained in order to be able to handle students who will be grappling with issues of sexuality, pregnancy, and parenthood. Licensing, training, and accrediting services need to be linked for all youth serving occupations, so as to ensure that professionals who work with teenagers can provide optimal services, programs, and referrals.

3. Legislative and policymakers need to be informed about teenage pregnancy related research so as to create a unity of purpose and mission with regard to adolescent pregnancy. Political agendas should not dictate the content and application of pregnancy prevention programs without heeding the experience and advice of those who work in the field, as youth workers and evaluators of prevention programs.

School-Based Prevention

At the present time school-based family life and sex education occurs sporadically. Little coordination exists between schools and social service agencies that provide or promote teen pregnancy prevention.

Policy and Program Options

1. When schools choose to offer family life and sex education, the curricula used should be developed and implemented based on proven methodology and content, while also respectful of the standards of individual communities.

2. Educators need the opportunity and resources to learn effective teaching methods for these topics.

3. Schools, with the involvement of the community, should be encouraged to offer effective family life and sex education courses as part of the child's educational experience, beginning in elementary school and progressing through high school.

4. There needs to be a thematic approach to education about pregnancy prevention. Sexual education needs to be delivered in more than just one class, for only one session a week. An important part of a thematic approach is involving other faculty members in the process so that they can tailor their curricula to complement pregnancy prevention programs.

5. Learning through direct service is another way to promote healthy attitudes and behaviors. Students should be encouraged to work in their communities. This will provide them with a greater sense of connection to and responsibility for their future, and the future of their community.

6. Schools should be encouraged to partner with local social and health service agencies to build upon the unique strengths and resources each can offer to the task of preventing teenage pregnancy.

Evaluation Strategies

Evaluation is a vital part of program development and implementation. Of course, evaluations of discrete interventions are easiest to conduct. In addition, there is a need for broader research which provides a better understanding of the larger issues that affect adolescent pregnancy prevention.

Policy and Program Options

New and ongoing individual intervention approaches should be evaluated for effectiveness and cost. This will better inform policymakers about what works and the cost of each intervention model. While there is a great deal known about what works and what doesn't in school settings, little is known about the models being actually used in local schools and their effectiveness.

Evaluation research should also measure community changes in other realms besides teenage pregnancy in order to answer such questions as: What other factors operate within the community to encourage or discourage adolescent pregnancy? How might these factors be mobilized to foster positive community change?

CHAPTER V: PREVENTING REPEAT PREGNANCIES TO TEENAGERS

Although most research has examined causes and consequences of first births to teenagers, pregnancies to teenagers who have already given birth occur with alarming frequency. In fact, one in every four teen births in California is a repeat teen birth. Furthermore, repeat births to teenagers have significant consequences with regard to outcomes for the children of teen mothers and teen mothers themselves.

What follows is an examination of the scope of the problem as it occurs across different age, ethnic, and socio-economic groups. We will examine why so many adolescents continue to bear children so soon after their first birth, and implications for prevention, with specific emphasis on what has been attempted and the types of programs that might work.

Repeat Pregnancies to Teen Mothers: Scope of the Problem

Research indicates that teenage parents understand the negative consequences of having additional children before they are able to provide adequate economic support. Nonetheless, many teen mothers become pregnant again within a few years.

In a study of the Teenage Parent Welfare Demonstration (Maynard & Rangarajan, 1994), 83 percent of the teenage mothers on welfare reported contraceptive use while 75 percent of these mothers reported using highly effective contraceptive methods such as the pill or IUD. Still, contraceptive use was not effectively maintained.

- Overall, one quarter of teen mothers had a second birth within one year. By the end of the second year, that number had increased to one half.

- 43 percent of teen mothers experienced one repeat pregnancy within three years of their first birth. Of these mothers, 21 percent experienced two repeat pregnancies within 3 years of their first birth.

- 75 percent of these repeat pregnancies were carried to term.

Which teenagers are at greatest risk for repeat pregnancies? Ethnicity, socio-economic status, age at first birth, marital status at first birth, and desirability of first birth all affect the likelihood that an adolescent will have additional children within two years of their first birth.

Teenager's Ethnicity and Age at First Birth

In a study of data from the National Longitudinal Study of Youth (NLSY), a representative sample of U.S. adolescents and young adults, Mott (1986) found that the younger the adolescent female who gives birth, the more likely she is to experience a repeat pregnancy within two years. For all ethnic groups:

- 26 percent of teenagers who first gave birth at age 16 or younger had a second child within 2 years;

- 20 percent of teenagers who first gave birth at ages 17 or 18 had a second child within two years;

- 22 percent of teenagers who first gave birth at ages 19 or 20 had a second child within two years.

Ethnic differences impacted these findings. Among Whites, age at first birth had less effect on the proportions of females who had a repeated birth within two years. Among Blacks, however, younger females who had experienced first births were significantly more likely than their older counterparts to have a second birth soon after the first.

Socio-Economic Status

As is the case for first pregnancies, socio-economic background, represented by parental level of education, also affects the pace of repeat pregnancies. Compared with teenage mothers whose parent(s) are high school drop-outs, teen mothers whose parent(s) are high school graduates are less likely to have a second child within two years. This is especially true for the youngest teen mothers (Mott, 1986).

Marital Status at First Birth

Contrary to conventional wisdom, teen mothers who marry prior to first birth are more likely to have a second child within two years than are their non-married counterparts (Mott, 1986). In addition, although marriage is linked with lower welfare dependency among teenage parents, educational attainment for teen mothers following childbirth is lower among teens who are married than those who are not (McLaughlin, Grady, Billy, Landale, Winges, 1986). Also, divorce rates in this age group average at about 90 percent.

Desirability of First Birth

Desirability of first birth is closely correlated with maternal age at first birth and timing of second birth. The older the adolescent at the time of first birth, the more likely that birth was desired. Furthermore, those mothers who reported wanting their first birth have a significantly higher probability of bearing a second child within two years. Although older teenagers are more likely to desire parenthood, many of the youngest teen parents also report desiring their first birth. Mott (1986) found that in the youngest subgroup of teen mothers (age 16 and younger), 37 percent of mothers whose first births were wanted had a second birth within 2 years.

Why so Many Repeat Pregnancies to Teenagers?

The correlates of repeat pregnancies to adolescents are not so different than those for first births: low socio-economic status, and accordingly, few educational and occupational aspirations. These problems are further compounded by the difficulties of becoming economically self-sufficient once a teenager has a child. In a study of teen mothers in New Chance, a program to encourage and help teen mothers to achieve economic self-sufficiency, Quint, Musick, and Ladner (1994) found the following:

- Some teen mothers became pregnant in an effort to secure the lasting affection of a new boyfriend or even at a new boyfriend's request, to prove his manhood.

- Many repeat pregnancies occurred when a teen mother was experiencing a major transition in her life, suggesting that some of these women may have used pregnancy and childbearing as an unconscious means to avoid potentially stressful situations.

- Although many teen mothers reported contraceptive use, many became pregnant anyway, suggesting that these women need more attention with regard to incorporating regular contraceptive use into their daily schedule, and that contraceptive counseling efforts should be increased during periods of crisis and transition.

Some Programs That Seek to Prevent Repeat Pregnancies

In 1988, Congress enacted the Family Support Act, legislation that was based on growing sentiment that welfare recipients should be encouraged to take responsibility for themselves and their children. A major provision of the Family Support Act was the Jobs Opportunities, and Basic Skills (JOBS) Program, that provided state welfare agencies with wide latitude to create and implement education, job training, job-readiness, employment placement, and other employment related activities. Accordingly, many of the programs described below were created in the wake of JOBS, and were designed to reduce repeat pregnancy to teenagers by increasing the self-sufficiency of teen parents.

Project Redirection. Project Redirection was an early effort (1980-1985) to provide comprehensive services to teen mothers ages 17 and younger. This community-based intervention program offered extensive social service support, education, training, mentoring, job placement, child care, family planning, and parenting education to 300 volunteers. An evaluation of the program indicates that it reduced the incidence of low birthweight, improved school continuation, and increased school enrollment. There was a modest increase in earnings in the short term. However, these gains disappeared over time. There was also a significant increase in repeat pregnancies, although the size of the sample was too small to draw any broad conclusions. Project Redirection was funded by several foundations in concert with the U.S. Department of Labor, and cost approximately $6,000 per participant per year to operate.

Job Start. Job Start was a 13-site demonstration operated between 1985 and 1988. Education, job training, and support services were offered to disadvantaged, young school drop-outs, about one-quarter of whom were teen parents. Job Start had a substantial impact on high school and GED completion, but no effect on earnings. This demonstration, which involved about 1,000 participants, also resulted in a statistically significant increase in repeat pregnancies. The funding for Job Start came from the U.S. Department of Labor, with additional support from a wide variety of foundations.

New Chance. The first large-scale, post-JOBS intervention directed toward teen parents, New Chance was a national demonstration program operated between 1989 and 1992 at 16 sites in 10 states. It targeted families headed by young mothers (ages 16 to 22) who had dropped out of school, given birth during their teen years, and were receiving AFDC. The limited education and

work experience of the participants put them at high risk of long-term poverty and welfare dependency (Quint 1994).

Participants were enrolled on a voluntary basis. Evaluation data are currently available for outcomes 18 months after mothers enrolled in the program. A final, 42-month evaluation is due in 1996. New Chance offered two phases of implementation. During Phase I, the participant's first months in the program, services were primarily delivered on-site. After the participant received her GED, or had been in the program for five months, she began Phase II, which was employment-driven. Case managers were expected to monitor their progress and provide guidance and support throughout the 18 months a teen mother might be enrolled. Child care was free throughout the program.

The program was supported by 28 government and philanthropic entities. The operating cost averaged approximately $6,500 per participant, and child care costs were an additional $2,600 per participant. The total cost was $9,100 over an 18-month period, or $6,066 per year per participant. Case management accounted for about half of the Phase I costs.

The outcomes of New Chance at its 18-month evaluation were disappointing. Compared with the control group, the women in the experimental group were more likely to have obtained a GED, although in actual numbers fewer than half of either group had done so. The experimental group were somewhat more likely to have earned college credits and be enrolled in college. However, the two groups were similar in reading skills, depression, stress, drug use, and health. Women in the experimental group were more likely to have a repeat pregnancy, and were less likely to be using contraception regularly. The women in the experimental group were more likely to be living with a boyfriend or husband, and the high repeat pregnancy is attributed to that factor. The two groups shared similarly short job tenures.

Phase I, which was intended to help participants procure an academic credential, was modestly successful. However, Phase II, which was designed to help participants get a job, was not. Two points are worth noting about New Chance. First, more than half of the participants never got to Phase II. Phase II was primarily delivered off-site, and required extensive work on the part of case managers to coordinate outside services. Many of the agencies involved did not have the capacity to work with such a complex population. Second, New Chance worked only with women who had already dropped out. As noted previously, these are women who, after the birth of a child, are very unlikely to return to school. Thus, the New Chance population is among the most challenging to work with, and their results demonstrate that this program could not overcome the disadvantage with which these young women started (Ivry 1994).

Elmira Home Visiting Program. Whereas the other demonstrations discussed in this paper were primarily based on a social service model, the Elmira Home Visiting Program addressed the challenges of adolescent parenthood from a public health perspective. Case management was also central to this program, however, Elmira case managers were registered nurses, who delivered services primarily through home visits. Home visits put the nurses in an ideal position to identify and help change those factors that put young mothers and their children at risk. Visits focused on maternal health habits, infant care giving, and personal accomplishment in relation to work, education and family planning. The program served 400 young, economically disadvantaged mothers having their first child, 47 percent of whom were teenagers (Olds 1988).

Some of the steps taken by the nurse home visitors included:

- encouraging women to clarify plans for completing their education;
- stressing that the decision to return to work or school following the delivery of a child should be made in the best interest of mother and child;
- helping interested women make connections to appropriate educational and vocational training services, and making plans for child care;
- advising them in finding jobs and in interviewing skills; and
- counseling women and their partners in family planning, including a detailed and thorough discussion of birth control devices.

An emphasis on family planning and postponing a second birth was made in the context of the young woman's desire to continue her education, work experience, and to achieve her goals with respect to family size. Family planning was not imposed on couples who articulated a desire for a large, closely spaced family.

Nurses used a detailed curriculum that was individualized for each participant. They carried small caseloads, 20-25 families, from birth until the child's second birthday. Nurses worked in teams of two, each partner backing up the other, so they had a knowledgeable colleague with whom to confer on a day-to-day basis. None of the registered nurses held baccalaureate degrees.

Two striking results in the adolescent subgroup made this small study noteworthy. By the 46th month postpartum, the nurse-visited, low-income, unmarried teen mothers showed an 82 percent increase in employment activity as compared to a control group. In addition, this group showed a 43 percent reduction in repeat births during the four years postpartum. They delayed the birth of their second child an average of 12 months longer. They also returned to school more rapidly than their control group counterparts. It may be that these teen mothers secured their place in the workforce by returning to school quickly and delaying their subsequent pregnancies successfully. Interestingly, most teens did not enter the workforce until two years after the program, most likely because they were unable to find work until they reached the age of maturity. Instead, those who had not graduated returned to school until that time (Olds 1994).

Teenage Parent Demonstration. Although this project, launched in 1986, predates the Family Support Act, it was designed along guidelines similar to the current JOBS program. The Teenage Parent Demonstration program operated in Illinois and New Jersey, at three sites (Chicago, IL; Newark and Camden, NJ). Participation by pregnant and parenting teens receiving AFDC was mandatory: 5,297 participants completed intake, one-half were assigned to participate in this demonstration. The participant group received a broad array of services. The other half were assigned to a control group for the purposes of evaluation, and continued to receive standard AFDC-related services (Maynard 1993).

Pregnant and parenting teens in the demonstration sites were required to:

- stay in school if they were attending school at the time of enrollment;
- return to school or enter adult basic education (ABE) if they had already dropped out;
- enroll in post secondary education if they had completed high school or had a GED;

- enroll in appropriate skills training program; or
- seek employment as an alternative to or after completing schooling.

Case management was the primary vehicle for service delivery. Case managers were former social service caseworkers who were trained to provide more comprehensive, ongoing services. Whereas normal caseloads can be as high as 150 per manager, caseloads in the Teenage Parent Demonstration were modest, between 50 and 80 cases per manager. Cost of the program was modest as well, approximately $2000 per recipient annually.

One of the unique features of the Teenage Parent Demonstration, apart from its mandatory nature, was the use of sanctions to encourage participation. When young mothers failed to comply with the requirements of the program, including enrollment, their case managers first warned, and then sanctioned them. The sanction constituted a considerable reduction in their monthly grant. In Chicago, the sanction was $166 out of an average monthly grant of $268; in New Jersey, the sanction was $160 out of an average $322 monthly grant. Sanction warnings tended to be more effective than sanctions themselves. Evaluators consider the sanctions crucial to the success of the program for a less than obvious reason. They attribute the power of the sanction not so much to its ability to motivate participants, but to its ability to motivate caseworkers, who persevered with clients to achieve compliance in order to avoid having to penalize them (Maynard 1994).

Unfortunately, results of the Teen Parent Demonstration are similar to those of New Chance. There was a 12 percent increase in general school participation over the control group, modest gains in job training and employment, a modest rise in earnings. These gains, however, were completely offset by the corresponding drop in AFDC or Food Stamps, resulting in no net gain to participants. The only real economic gains made were by those who obtained employment, and the experimental group lagged behind controls in this regard. Once again, there was a small, but significant, increase in repeat pregnancies and second births.

Some of the disappointments of the Teenage Parent Demonstration, as well as the shortcomings of other models discussed in this chapter, are related to systemic dysfunction in the public infrastructure serving youth in these communities. The educational opportunities available to young mothers are limited and often poorly programmed. Public schools often can not or do not commit the remedial resources necessary to bring this special population along. Adult Basic Education (ABE) programs are usually designed for older learners and may not meet the developmental needs of teens. Training options are particularly poor for non-English speaking adolescents. Regulatory barriers exist to young mothers participating in many programs. They may not meet the various age and educational requirements mandated by states or local jurisdictions (i.e., minimum ages for GED completion, maximum ages for participation in alternative settings, parental waiver requirements). In addition, the extremely disorganized lives of these young families, partly brought on by the AFDC requirement that they live separately from their families, make family planning very challenging. Without consistent housing and supervision, many adolescent mothers cannot exercise enough control over their lives to effectively practice birth control (Maynard 1993, 1994).

Ohio LEAP. Ohio's Learning, Earning, and Parenting (LEAP) program has been operating in 12 counties since 1989. The program requires teens receiving AFDC who are still in school to attend

regularly, and those who have dropped out to return to school or pass their GED. LEAP provides case management, transportation, and child care assistance, while relying on the educational system to provide other necessary services. The direct cost of LEAP varies, but during the four-year evaluation period in Cleveland, it was approximately $537 per teen per year, or a total of $651 per teen over the average 21-month spell in LEAP. The bulk of this cost was in case management and child care. This does not cover the cost of educational services, which were borne by the educational system and varied widely depending on the needs of individual teens (Long 1994).

LEAP is distinctive for several reasons. Along with sanctions imposed in the Teen Parent Demonstration, LEAP offers teens incentives in the form of bonuses added to their AFDC grants. Sanctions and bonuses are tied to program and school enrollment and attendance. A compliant attendance record (2 or fewer unexcused absences, four or fewer total absences for high school per month) earns a monthly bonus of $62. Failure to meet attendance requirements is sanctioned by a $62 reduction in the monthly AFDC grant. Given the average $274 award, this is a 30 percent reduction. Teens have several opportunities to challenge the sanction once it has been initiated by the case manager, so there is a three-month lag between the month of attendance and the corresponding bonus or sanction. A teen may be temporarily exempted from LEAP during the last seven months of pregnancy if she is caring for a baby less than three months old, is unable to obtain transportation or child care, or for other specified reasons. Because the number of sanctions is equal to or exceeds the number of bonuses paid, this part of LEAP is cost neutral. However, costs of establishing the computerized tracking system used for following attendance and grants were considerable.

LEAP participation ends with completion of high school or receipt of a GED. It has no job-training component and no comprehensive case management services that might include health, parent education, or housing assistance. It is a narrowly focused program with clear objectives.

In the most recent evaluation, at the end of its third year, LEAP was found to have a small but significant impact on high school attendance during the first two years, but an insignificant impact on attendance during the third year. Some of this drop-off is attributed to the small increase in GED attainment. Combined rates for high school completion and GED attainment were 5.6 percent higher than those of the control groups, but the actual percentages of young women completing either high school or a GED were less than 25 percent for both groups. LEAP was more successful in motivating teens who already enrolled to finish school than in bringing back those teens who had left the school system.

Sanction activity for Cleveland teens in LEAP changed over time. Initially, participants earned more bonuses than sanctions, but as their length of participation increased, this trend reversed. There are several explanations offered for this. Those who completed school or attained a GED early in their LEAP tenure would be eligible for neither sanctions nor bonuses following completion. Others who enrolled early in school and then dropped out, would have received bonuses initially and then only sanctions. Some who were initially exempt due to pregnancy might have had neither sanctions nor bonuses at the beginning, then only sanctions if they refused to comply when their exemption ended. The 68 percent of teens who ever qualified for sanctions received an average of 9 sanctions requests during their LEAP tenure. Forty-five percent

qualified for 9 or more sanctions, and 24 percent never received a bonus. This high rate of sanctioning indicates that LEAP's incentive structure was ineffective in changing the behavior of teen parents.

ROUNDTABLE CONCLUSIONS AND POLICY AND PROGRAM OPTIONS

Discussion at the last roundtable focused on a number of interrelated issues, in particular (1) the lack of holistic assessment and treatment of the problem of adolescent pregnancy due to categorical funding, and (2) implications of this failure with regard to service provision and evaluation. In addition, recurring issues from previous roundtables—parent education, child and adolescent abuse, and the role of males in our society—were again discussed.

Categorical Funding

There was a lively debate about the issue of categorical funding with regard to health programs that include family planning. On one hand, it was pointed out that with classification and categorization, programs and evaluations of such programs are duplicated. On the other hand, categorical funding can also lead to duplicate funding for many programs that have overlapping goals. Categorization impedes efforts to find the unifying themes across interventions, and to create interventions and linkages that integrate such themes in more comprehensive interventions. In addition, categorical funding of programs make it very difficult to access services, particularly for young pregnant adolescent females.

Policy and Program Options

Categorical funding for programs exists because of the lack of a universal health care system. Although "de-categorization" was recommended as a way to facilitate creation and implementation of broad-based, integrated programs and services, there was warning that any health programs that include family planning will fall prey to political battles over what family planning should be.

Privatization of family planning services might be one way to avoid such political considerations. It was suggested that analyses be conducted on the costs and benefits of privatizing public health services, including family planning services, in the hopes that this might diminish political conflicts.

Comprehensive Assessment

The current funding structure was cited as a major reason that existing services to reduce teenage pregnancy do not include a comprehensive assessment nor address developmental and environmental problems of adolescents. Rather, interventions target one issue at a time, such as teen pregnancy, ignoring the other issues in an adolescent's life that may be affecting his or her sexual behaviors.

One of the speakers reflected that while she had worked at various social services agencies over the course of the last twenty years (substance abuse programs, teen pregnancy prevention

programs, employment programs), the clients were always the same. They attended whatever program was receiving the most funding at the time, and was therefore most available to provide necessary services. Nonetheless, their "problem" was then defined as what they came in for, thereby fracturing the services available to them when what was needed was a more holistic approach.

Policy and Program Options

There was uniform agreement that a systematic and comprehensive approach works best to reduce adolescent social problems such as adolescent pregnancy.

- A bio-psycho-social perspective needs to be taken to correctly assess individual needs with regard to adolescent pregnancy and other social problems.

- What particular services are delivered also varies by the needs of and resources in each community. Therefore, a more holistic perspective also needs to be assumed with regard to designing appropriate interventions to reflect each community's needs.

- If comprehensive services are to be delivered, cross-training is essential. Workers need to be trained in all aspects of service delivery. For instance, it is not enough to be trained in family planning if you are serving the need of pregnant teens who are suffering domestic violence, and who need educational assistance to help them remain in school.

Services to Adolescents

Overall, adolescents as a population are not well served. In the last ten years, all services related to adolescent morbidity (i.e.: mental health services, family planning services, literacy services) have been reduced and in some cases eliminated.

Policy and Program Options

It was suggested that society hold negative beliefs and opinions about adolescents, and that these negative attitudes impede the provision of appropriate and adequate services. Instead of viewing adolescents in a negative light, as rebellious and problematic, it is important to provide supportive services that help adolescents through the transition to adulthood.

Services to adolescents should be comprehensive, not fragmented. Communities, particularly communities in need, could benefit from comprehensive adolescent services centers. These centers could provide a wide range of services to adolescents: mental and physical health, family planning, educational assistance, and recreation. This will better ensure that healthy development occurs across all these realms, and that services reflect that holism.

Evaluation

Although there have been countless evaluations of adolescent pregnancy prevention programs and programs to prevent repeat pregnancies to adolescents, in many cases, evaluations have not been

standardized, and are therefore not comparable. For instance, there is little consistency on how we define the problem and the sub-populations that experience these problems. For instance:

- Who are high risk youth?
- How do we define pregnancies that do not end in live birth?
- What are positive outcomes for pregnancy prevention programs?

Politicization introduces additional conflicts with regard to defining the problem and positive outcomes. Is teenage pregnancy the problem, or is it teenage parenthood? If it is teenage pregnancy, then is abstinence the only positive outcome, or can contraceptive use be an equally positive one? If the problem is teenage parenthood, then is abortion a positive outcome? These questions are rife with political and values conflicts that need to be addressed before evaluations can become more useful.

Policy and Program Options

There is a need for standardized measures that can be used in all evaluations of family planning programs, services, and interventions. While evaluations should include other measures as well, sharing some common measures will facilitate comparability of programs.

In addition, political considerations should not dominate evaluations. Evaluations are of service when applied and assessed objectively.

Parents of Pregnant and Parenting Adolescents

Services for pregnant and parenting adolescents tend to neglect the role of the adolescents' parents. What is it about the adolescent's family constellation that allowed for him or her to become a teenage parent?

Policy and Program Options

Services to prevent both first and repeat pregnancies to teenagers need to also focus on the parents of these teenagers.

- Parents of teenagers need to be educated and empowered to talk to their teenagers about pregnancy prevention, and to encourage them to continue their education regardless so as to maximize their opportunities.
- Services to parents of teenagers should not only be implemented after an adolescent becomes pregnant. These services should be a form of prevention, delivered in conjunction with services and interventions for adolescents themselves.

Sexual Abuse

Sexual abuse is an issue that seems inexorably connected to adolescent pregnancy in myriad ways. Many teen mothers report that they were sexually abused as children. Furthermore, so many fathers of children born to teens are considerably older than the teenage girls themselves. One must consider whether these unions, in and of themselves, are a form of sexual abuse.

Policy and Program Options

Sexual abuse is difficult to prevent, but clearly, it must be identified and treated if we are to prevent or at least reduce a large number of today's teenage pregnancies.

In addition, the issue of sexual abuse of males needs to be examined and treated. There is growing evidence that that male children are also sexually abused in large numbers. Male adolescents who have been sexually abused will have as many developmental difficulties as their female counterparts. Furthermore, as in the case of abused adolescent girls, these difficulties may manifest themselves in adverse sexual behavior. Until we find a way to assess and treat sexual abuse of males as well as females, we will never stem the problem of adolescent pregnancy and parenthood.

1. Service delivery agents who work in the field of adolescent pregnancy prevention, be it prevention of first or repeat births, need to be trained to work with the issue of sexual abuse.

2. Home visitors in particular, whose job it is to form a therapeutic and helping relationship with the adolescent parent, must be especially well-trained in this regard, and prepared to make appropriate recommendations with regard to sexual abuse that may still be occurring in the adolescent's home.

CHAPTER VI: STATE PROGRAMS RELATING TO TEEN PREGNANCY AND PARENTHOOD[1]

California Youth Authority

Young Men as Fathers Parenting Program

The California Youth Authority is the largest youth correctional agency in the nation, with 9,800 young people incarcerated in 11 institutions and 4 forestry camps, and an additional 5,900 on parole. Their ages range from 12 to 24 years old, with an average age of 19. Over 23 percent of the males are already fathers.

The Young Men as Fathers Program has three goals: to reduce the maltreatment and delinquency among a population of children whose fathers are criminal offenders in the Youth Authority; to demonstrate that a well run parenting program for this population will make them more effective than the fathers who raised them; to give the offenders a positive purpose that will promote self-esteem and success in their lives. A 60-hour culturally sensitive classroom curriculum was developed with input from departmental staff, outside parenting experts, and wards who are fathers. Special family visiting day activities reinforce what the wards have learned in the program. Classes began in July 1993. Five hundred and ten wards completed classes by December 31, 1994. A mentor program is being added as part of the project. The program continues to be implemented at its original sites. It was expanded in July, 1994, to include two more sites.

State Department of Health Services

Early Teen Outreach and Counseling Program (ETCP) and Teen SMART

The Expanded Teen Counseling Program (ETCP) and the Teen Demonstration Projects which were originally funded in 1992 as a clinical services program for teens has now come to a close. These successful programs will be replaced by a teen services program called Teen SMART.

Teen SMART builds on the experiences of ETCP and Teen Demonstration Projects where the utilization of an adolescent risk assessment tool, enhanced counseling and innovative community outreach strategies provided adolescent clients with more individualized and enriched family planning clinical services. In Teen SMART, the approach to teen assessment and counseling has been streamlined and incorporated into the State Department of Health Services Office of Family Planning's (OFP) fee-for-service model. Standardized counseling guidelines have been developed and will be used by all Teen SMART clinic service providers. The goals of Teen SMART are to reduce the incidence of sexually transmitted diseases (STDs) and unintended pregnancy by minimizing sexual risk-taking behavior and improving contraceptive compliance among sexually

[1]The program descriptions for the California Youth Authority and the State Department of Health Services were generously provided by staff from the individual state programs described. Descriptions of California Department of Education Programs are summarized from the report *Teen Pregnancy: A Blueprint for Comprehenisive California School-Based Programs* prepared by the Department in 1990.

active teens. In addition to the assessment/counseling component of Teen SMART, clinic outreach and case finding activities to identify sexually active teens at risk for pregnancy and assist them to access clinical family planning services. Sixty-five OFP clinical contractors will be funded to provide counseling; and of those contractors, fifteen will also be funded to implement client outreach programs.

Education Now and Babies Later (ENABL)

Education Now and Babies Later (ENABL) is the educational and informational component of Governor Wilson's comprehensive 1992 initiative to reduce the incidence of teenage pregnancy in California.

The ENABL campaign is being implemented by the California Department of Health Services, Office of Family Planning, for young men and women between the ages of 12 and 14 to help them learn and practice the skills necessary to postpone sexual activity. ENABL is unique in that it is a multi-faceted effort encompassing a direct education curriculum, mass media support, and parental and community involvement. ENABL has been designed to open communication about the issue of teen pregnancy and its prevention.

ENABL is based on the belief that young people engage in early sexual activity because of powerful societal and peer influences. ENABL provides education to help adolescents handle their sexual maturation and resist pressures to become sexually active—pressures from peers, public attitudes and behaviors, and the representation of sex in the media.

The ENABL curriculum is "Postponing Sexual Involvement" (PSI), a proven program developed by Marion Howard, Ph.D., of Emory University in Atlanta, Georgia. It is being presented by community-based agencies in schools and other community settings. While adolescents learn and practice refusal skills that enable them to feel confident that they can say "no" to sexual involvement and have their "no" accepted, it also identifies more positive options available to them for expressing personal feelings beyond sexual activity.

The ENABL curriculum consists of five lessons, 45 to 60 minutes in length. Sessions are set up around a group process to increase interaction and discussion. There is a companion series for parents of young teens.

The Office of Family Planning (OFP) has funded 28 ENABL direct education projects through June 1997. These projects are being coordinated by local nonprofit educational, health, and social service agencies, with the majority of the projects operating in counties with the highest rates of teen birth. The ENABL curriculum has reached more than 141,000 teens throughout 30 California counties. In addition, OFP has funded a statewide media effort to support the ENABL program and the messages it is delivering to teens, parents, and the general community.

California Department of Education

Healthy Kids, Healthy California

Healthy Kids, Healthy California is a statewide effort to equip students with the knowledge, skills, and values they need to take control of their own good health. This initiative is a comprehensive strategy for reaching these goals through enlisting the help of the entire school staff, administrators, parents, and the community. The eighty component areas are health education, physical education, health services, nutrition services, staff helath promotion, safe and healthy school environment, skilled and caring counseling, and parent/community involvment.

Pregnant Minor Program (PM)

Originally established as a Special Education program, the Pregnant Minor program enables school districts and county offices of education the opportunity to develop educational programs for pregnant students providing academic instruction, perinatal education, family planning information, nutritional education, and frequently, counseling. The design and components of invidivual PM programs vary from school to school. They may be located on or near a comprehensive or continuation school or may be a self-contained program at a school site or another facility such as a church or community service organization. Some sites continue to educate mothers beyond pregnancy and often do so by combining education funds with job training and private funding sources.

School-Age Parenting and Infant Development Program (SAPID)

The School-Age Parenting and Infant Development programs, modeled after the Vera Casey program in Berkeley, California, encourage parenting teen students to remain in school by providing child care on or near the school site, transportation to and from school and day care, and parenting education coursework. State policy encourages the integration of SAPID programs into the regular school curriculum either at a comprehensive or a continuation high school.

ROUNDTABLE SPEAKERS

Policy Roundtable #1: **Underlying Developmental, Psycho-Social, and Environmental Factors Associated With Teenage Pregnancy**
(June 30, 1995)

Guest Speakers

- Judith Musick, Ph.D., developmental psychologist, former Director of Ounce of Prevention in Chicago, IL and author of Young, Poor and Pregnant.
- Mike Males, demographer and Social Ecology doctoral candidate at U.C. Irvine.
- Andrea Goetz, Program Coordinator, Youth Education and Support Services (YESS!).
- Ed Melia, pediatrician and former director of California's Adolescent Family Life Program

State Speakers

- Walt Jones, Community Services Consultant, Office of Prevention & Victims Services, California Youth Authority
- Marilyn Schuyler, Education Now and Babies Later (ENABL) and the Information and Education Program, Office of Family Planning, Department of Health Services
- Jane Boggess, Teen Services Program and Teen SMART, Department of Health Services

Policy Roundtable #2: **Teenage Pregnancy Prevention Strategies and the Media**
(July 7, 1995)

Guest Speakers

- Bronwyn Mayden, M.S.W., Director of the Florence Crittenton Division and Program Director, Adolescent Pregnancy Prevention and Parenting Services for the Child Welfare League of America.
- Katharine Heintz-Knowles, Ph.D., Assistant Professor, School of Communications, University of Washington, Seattle, Washington.

State Speakers

- Colleen Stevens, M.S.W., Chief, Media Campaign Unit, Tobacco Control Section, Department of Health Services.
- Julie Linderman, M.P.H., Health Education Consultant, Office of Family Planning, Department of Health Services.

Policy Roundtable #3: **School- and Community-Based Teenage Pregnancy Prevention Strategies**
(July 13, 1995)

Guest Speakers

- Karin Coyle, Ph.D., Associate Director of Research, ETR Associates.
- Charles "Cal" Crutchfield, M.S., Director of Prevention Programs, Boys & Girls Club of America.
- Suzane Henderson, State Coordinator, Teen Outreach Program.
- Vandana Kohli, Ph.D., Assistant Professor, Sociology/Anthropology Departments, California State University, Bakersfield.

State Speakers

- Gail Maurer, Healthy Kids, Healthy California, California Department of Education
- Janet Wetta, M.P.H., Office of Family Planning, State Department of Health Services
- Arlene Roberton, Children, Youth, Families and Communities Division, State Department of Alcohol and Drug Programs.

Policy Roundtable #4: **Preventing Repeat Pregnancies**
(July 20, 1995)

Guest Speakers

- Mary Wagner, Ph.D., Program Director of Education and Human Services Research, SRI, International.
- Renee Cameto, Research Social Scientist, SRI, International.
- Terry Carrilio, Ph.D., Project Director, South Bay Home Support Project, Center for Child Protection, San Diego Children's Hospital.

State Speakers

- Sharlyn Hansen, Adolescent Family Life Program (AFLP), State Department of Health Services.
- Ronda Simpson-Brown, Consultant, School Interventions & Educational Options, California Department of Education.
- Jane Boggess, Ph.D., Chief, Office of Family Planning, State Department of Health Services.
- Marjorie Kelly, Deputy Director, State Department of Social Services.
- Nancy Remley, Manager, Cal-Learn Program, State Department of Social Services.

ROUNDTABLE AGENDAS

1995 CAFIS TEENAGE PREGNANCY PREVENTION
POLICY ROUNDTABLE SERIES

Policy Roundtable #1: Underlying Developmental, Psycho-Social, and Environmental Factors Associated With Teenage Pregnancy

FRIDAY, JUNE 30, 1995, 8:45 A.M. - 12:00 NOON
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:05 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:40 A.M. ***PRESENTATION #1***

Judith Musick, Ph.D., developmental psychologist, former Director of Ounce of Prevention in Chicago, IL and author of Young, Poor and Pregnant. Dr. Musick will discuss the psycho-social and environmental factors that are so often present in the lives of teenage mothers and how these factors can lead to teenage pregnancy.

9:40 - 10:00 A.M. ***PRESENTATION #2***

Mr. Mike Males, demographer and Social Ecology doctoral candidate at U.C. Irvine. Mr. Males will review his analysis of maternal/paternal age data.

10:00 - 10:15 A.M. ***PRESENTATION #3***

Andrea Goetz, Program Coordinator, Youth Education and Support Services (YESS!). Ms. Goetz will discuss the relationship between male violence and teen pregnancy.

10:15 - 10:30 A.M. ***PRESENTATION #4***

Ed Melia, pediatrician and former director of California's Adolescent Family Life Program.

10:30 - 11:00 A.M. ***STATE DISCUSSANT PRESENTATIONS***

Walt Jones, Community Services Consultant, Office of Prevention & Victims Services, California Youth Authority
Marilyn Schuyler, Education Now and Babies Later (ENABL) and the Information and Education Program, Office of Family Planning, Department of Health Services
Jane Boggess, Teen Services Program and Teen SMART, Department of Health Services

11:00- 11:45 A.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

11:45 - NOON ***WRAP-UP***

1995 CAFIS TEENAGE PREGNANCY PREVENTION
POLICY ROUNDTABLE SERIES

Policy Roundtable #2: Teenage Pregnancy Prevention Strategies and the Media

FRIDAY, JULY 7, 1995, 8:45 A.M. - 12:00 NOON
LIBRARY & COURTS II BUILDING
900 N STREET, ROOM 340
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:10 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:35 A.M. ***PRESENTATION #1:***

Bronwyn Mayden, M.S.W., the Director of the Florence Crittenton Division and Program Director, Adolescent Pregnancy Prevention and Parenting Services for the Child Welfare League of America. Ms. Mayden was formally the Executive Director of the Governor's Council on Adolescent Pregnancy in Maryland.

9:35 - 10:00 A.M. ***PRESENTATION #2:***

Katharine Heintz-Knowles, Ph.D., Assistant Professor, School of Communications, University of Washington, Seattle, Washington. Dr. Heintz-Knowles will discuss how children and teens are depicted in the media and the relationship of these depictions to teenage sexual behavior and pregnancy.

10:00 - 10:10 A.M. ***BREAK***

10:10 - 11:00 A.M. ***STATE DISCUSSANT PRESENTATIONS***

Colleen Stevens, M.S.W., Chief, Media Campaign Unit, Tobacco Control Section, Department of Health Services. Ms. Stevens will describe the anti-smoking media campaign and factors relevant to designing an effective teen pregnancy prevention media campaign.

Julie Linderman, M.P.H., Health Education Consultant, Office of Family Planning, Department of Health Services. Ms. Linderman will describe the media component of ENABL (Education Now and Babies Later).

11:00- 11:45 A.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

11:45 - NOON ***WRAP-UP***

1995 CAFIS TEENAGE PREGNANCY PREVENTION POLICY ROUNDTABLE SERIES

Policy Roundtable #3: School- and Community-Based Teenage Pregnancy Prevention Strategies

THURSDAY, JULY 13, 1995, 8:45 A.M. - 12:00 P.M.

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:10 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:10 - 9:30 A.M. ***PRESENTATION #1:***

Karin Coyle, Ph.D., Associate Director of Research, ETR Associates. Dr. Coyle will discuss the evaluative work she and co-researcher Doug Kirby have done regarding school-based curriculum.

9:30 - 9:50 A.M. ***PRESENTATION #2:***

Charles "Cal" Crutchfield, M.S., Director of Prevention Programs, Boys & Girls Club of America. Mr. Crutchfield will discuss the Smart Moves Program, a community-based a life options program provided in local Boys & Girls Clubs throughout the country.

9:50 - 10:10 A.M. ***PRESENTATION #3:***

Suzane Henderson, State Coordinator, Teen Outreach Program. Ms. Henderson will describe TOP and its effectiveness as a community-based teenage pregnancy prevention model.

10:10 - 10:30 A.M. ***PRESENTATION #4:***

Vandana Kohli, Ph.D., Assistant Professor, Sociology/Anthropology Departments, California State University, Bakersfield. Dr. Kohli will discuss the results of her recent survey of school-based teen pregnancy prevention activities.

10:30 - 10:40 A.M. ***BREAK***

10:40 - 11:10 A.M. ***STATE PRESENTERS/DISCUSSANTS***

Gail Maurer, Healthy Kids, Healthy California, California Department of Education
Janet Wetta, M.P.H., Office of Family Planning, State Department of Health Services
Arlene Roberton, Children, Youth, Families and Communities Division, State Department of Alcohol and Drug Programs

11:10- 12.00 P.M. ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

1995 CAFIS TEENAGE PREGNANCY PREVENTION
POLICY ROUNDTABLE SERIES

Policy Roundtable #4: Preventing Repeat Pregnancies

THURSDAY, JULY 20, 8:45 A.M. - 12:00 NOON
LIBRARY & COURTS II BUILDING, 900 N STREET, ROOM 340
SACRAMENTO, CALIFORNIA

ROUNDTABLE AGENDA

8:45 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:05 A.M. ***WELCOME, INTRODUCTIONS AND ROUNDTABLE OVERVIEW***

Anne Powell, M.S.W., CAFIS Project Director

9:05 - 10:05 A.M. ***PRESENTATIONS***

M*ary Wagner, Ph.D., Program Director of Education and Human Services Research, SRI, International*. She will discuss her evaluation of Teen Parents As Teachers, a program funded by the State Department of Social Services. (20 minutes)

Renee Cameto, Research Social Scientist, SRI, International. She will discuss her evaluation of the Young Teen Parents Collaborative based in San Francisco. (20 minutes)

Terry Carrilio, Ph.D., Project Director, South Bay Home Support Project, Center for Child Protection, San Diego Children's Hospital. She will discuss their new home visitation program and how, among other things, it will reduce repeat teenage pregnancies. (20 minutes)

10:05 - 10:15 A.M. ***BREAK***

10:15 - 11:05 A.M. ***STATE PRESENTERS/DISCUSSANTS***

Sharlyn Hansen, Adolescent Family Life Program (AFLP), State Department of Health Services (10 minutes)

Ronda Simpson-Brown, Consultant, School Interventions & Educational Options, California Department of Education (10 minutes)

Jane Boggess, Ph.D., Chief, Office of Family Planning, State Department of Health Services (10 minutes)

Marjorie Kelly, Deputy Director, State Department of Social Services (10 minutes)

Nancy Remley, Manager, Cal-Learn Program, State Department of Social Services (10 minutes)

11:05- 12:00 NOON ***DISCUSSION AND IDENTIFICATION OF STATE POLICY AND PROGRAM OPTIONS***

ROUNDTABLE PARTICIPANTS

POLICY ROUNDTABLE #1
JUNE 30, 1995
PARTICIPANTS

Terry Anderson
Consultant
President Pro Tempore of the Senate

Ellen Dektar
Senior Consultant
Senate Health and Human Services

Rachel Doherty
Office of Child Development and Education
Office of the Governor

Aurora Dominguez
Specialist
Office of Child Abuse Prevention
State Department of Social Services

Thelma L. Eaton
Consultant
Senate Select Committee on Family
Preservation and Teenage Pregnancy Prevention

Laura Hill
Chief
Perinatal, Children, and Families Branch
State Department of Alcohol & Drug Programs

Karen Holcomb
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Child Welfare Services Bureau
State Department of Social Services

David Illig, Ph.D.
Sr. Research Policy Analyst
California Research Bureau
California State Library

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Julie Linderman, M.P.H.
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Tracey Rattray, M.P.H., M.S.W.
March of Dimes Birth Defects Foundation,
Greater Bay Area Chapter

Nancy Remley
Manager
Cal-Learn Program
State Department of Social Services

Lonetta Riley
Senior Program Specialist
California Office of Criminal Justice Planning

Don Saylor
Assistant Director
Office of Prevention and Victims Services
California Youth Authority

Joel Schwartz
Fiscal and Policy Analyst
Legislative Analyst's Office
Joint Legislative Budget Committee

Bessie Tichauer
Youth Service Coordinator
Library Development Services Bureau
California State Library

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